Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# Hospital Provider Class Plan Detailed Report 2006-2007

# EXECUTIVE SUMMARY

## Goal Achievement

BCBSM met the access and quality of care goals during the reporting period. Although the cost goal for the hospital provider class was not independently met, there is competent, material and substantial information to support a determination that the failure to achieve the goal was reasonable in accordance with Section 510(1)(b) of PA 350.

## Cost Performance

During the 2006-2007 reporting period, the two-year average percent change in hospital payments per 1000 members increased 21.8 percent. The PA 350 cost goal was to limit the increase to 4.6 percent. The trend was due to an average increase in use of 22.7 percent for inpatient admissions and 18.8 percent for outpatient visits. There were a number of factors that influenced hospital payments. The major factors are summarized below:

- Although traditional membership experienced another year of decline, utilization of hospital benefits by existing members grew considerably. This decline resulted in fewer members over which to spread the cost of increased admissions and outpatient visits.
- Circulatory, musculoskeletal, digestive and respiratory conditions experienced a three-year payout that accounted for 55 percent of total inpatient payments. Many of the top 50 diagnoses included services for percutaneous transluminal coronary angioplasties (PTCAs), coronary artery bypass grafts (CABGs), joint replacement, rehabilitation, extracorporeal membrane oxygenation (ECMO) or tracheotomy, obesity conditions and pneumonia.
- Surgery, laboratory/pathology and diagnostic X-ray accounted for 70 percent of the total three-year outpatient payout. In many respects, these top three types of service are used in conjunction with one another to provide patient care. Review of the surgical and diagnostic X-ray types of service gave the impression that the Traditional hospital membership is an older, potentially less healthy population.
- The majority of hospital payments were for members in the age category 55 years and older, a population for which the demand for hospital care and health resources will rise as they continue to age.

## Access Performance

There was a 100 percent formal hospital participation rate throughout the state to ensure the availability of inpatient and outpatient services to each BCBSM member. Major factors affecting access performance during this reporting period included:

- Effective communications with hospitals, such as BCBSM publications, on-line assistant tools, and provider consultants helped maintain a strong working relationship with hospitals.

- BCBSM's revised reimbursement methodology, which is outlined in the provider participation agreement, provided hospitals with equitable income to provide services to our members.
- Financial incentives offered to hospitals for focusing on quality improvement measures, hospital efficiency and collaborative quality initiatives help to impact the safety and quality of services provided to the Michigan community.
- Hospital Satisfaction Surveys measured hospital leaders' and staffs' satisfaction with BCBSM's services, operations and hospitals' overall relationship with BCBSM. The survey results helped BCBSM assess what was done well and where opportunities for improvement exist.

## Quality of Care Performance

BCBSM ensured that hospitals met and abided by reasonable standards of health care quality. Major factors affecting quality of care performance during this reporting period included:

- Qualification standards required for participation ensured that providers were appropriately licensed and accredited.
- Quality controls implemented through a variety of audits helped enforce that services rendered were medically necessary and provided in the appropriate setting.
- Quality management initiatives, including the Participating Hospital Agreement Pay for Performance Program and several other programs promoted safety, improved community health and ensured the delivery of high quality health care.
- Effective provider relations, including the contract administration process and the provider appeals process, helped ensure quality care was available to BCBSM members.

# PLAN OVERVIEW

## Providers

Short-term general acute care hospitals, short-term acute psychiatric hospitals and intensive rehabilitation hospitals.

## Qualifications

Licensed by the state of Michigan; certified by the Centers for Medicare and Medicaid Services (CMS); accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or American Osteopathic Association (AOA) or the Commission on Accreditation of Rehabilitation Facilities.

## Participation Status

Formal basis only

## Covered Services

BCBSM reimburses only for covered services provided by a participating hospital in accordance with member certificates*. Services provided at a hospital include but are not limited to:

- Room and board
- Surgery
- Maternity care and delivery
- Newborn care
- Emergency treatment
- Dialysis
- Physical therapy
- Chemotherapy
- Pathology and laboratory
- Radiology – diagnostic
- Observation bed
- Medical supplies

* Emergency services may also be covered by an accredited nonparticipating hospital.

## Benefit Issues

There were no benefit issues in this reporting period.

## Plan Updates

Effective July 1, 2007, changes were implemented for the Peer Group 5 hospitals. The changes included a modification to reimbursement and to the definition of a Peer Group 5 hospital.

The specific changes for Peer Group 5 hospitals are as follows:

- The reimbursement methodology continues to be a percentage of approved charges, but approved charges are set at a level that provides a 3 percent average profit margin for efficiently incurred costs. This results in lower reimbursement than what some Peer Group 5 hospitals previously received.

- Originally, the definition of a Peer Group 5 hospital was a hospital located in a rural area with fewer than 100 licensed beds and fewer than 2000 annual admissions. This definition was changed to a hospital located in a rural area with fewer than 100 beds and fewer than 6000 equivalent admissions (a combination of outpatient visits and inpatient admissions). A Peer Group 5 hospital also cannot be a specialty or limited service hospital without emergency room services.

- Originally, reimbursement did not include charity care. Now, hospital cost is defined to include the cost of uncompensated care (charity care and bad debt) as well as any funding shortfall associated with governmental programs.

- A pay for performance program was developed that puts a portion of the hospital reimbursement at risk.

- Reimbursement rates will be updated annually using the same formula-driven process that is used for Peer Groups 1-4.

- Reimbursement and cost levels will be reassessed every three years to determine whether there is a need to make adjustments.

- Hospitals will be required to annually attest that the hospital's submitted charges do not exceed the amount it charges other non-governmental third-party payers. Violations of this requirement will subject the hospital to payment recoveries from BCBSM.

# EXTERNAL INFLUENCES

## Market Share

Table 1 illustrates BCBSM's commercial (private) market share for members with Traditional hospitalization benefits. As shown, BCBSM's share of the commercial market in Michigan decreased in every region between 2006 and 2007. Total market share in Michigan decreased from 4.2 percent in 2006 to 3.1 percent in 2007. The loss in BCBSM membership was primarily due to members being offered more managed care products like PPOs to meet market demands. Although Traditional coverage offers greater access to providers, managed care offers a wider range of preventative services and lower out-of-pocket expenses for members who stay in the network. The additional loss in the Traditional membership is due to corporate downsizing by BCBSM customers or loss of groups to competitors.

**Table 1**
**Traditional Hospital Share of Michigan Market**

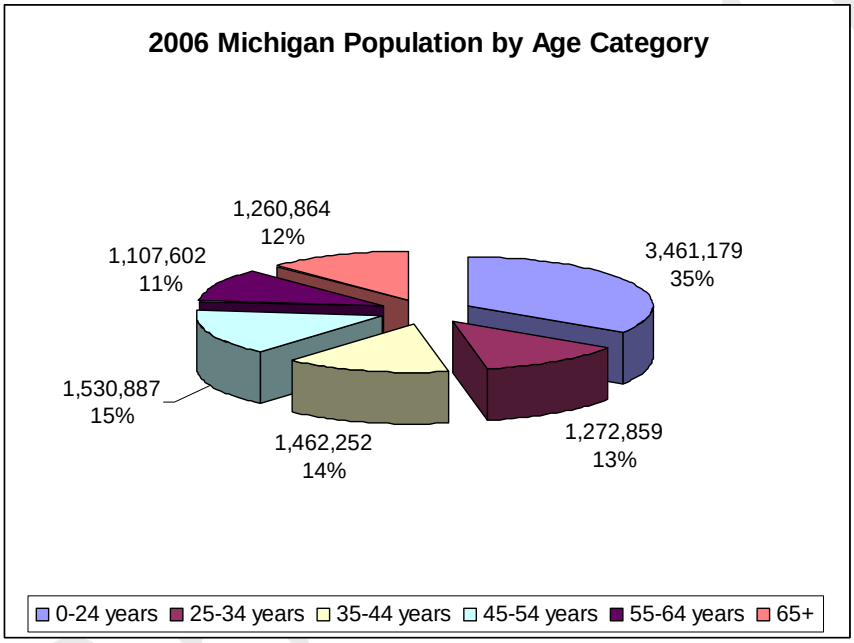
| Region | 2007 Michigan Population* | 2007 BCBSM Hospital Members* | 2007 Market Share | 2006 Michigan Population* | 2006 BCBSM Hospital Members* | 2006 Market Share |
|---|---|---|---|---|---|---|
| 1 | 3,046,972 | 94,404 | 3.1% | 3,185,649 | 129,353 | 4.1% |
| 2 | 512,279 | 12,596 | 2.5% | 524,273 | 20,364 | 3.9% |
| 3 | 421,019 | 14,501 | 3.4% | 452,036 | 20,960 | 4.6% |
| 4 | 365,387 | 8,231 | 2.3% | 376,840 | 13,004 | 3.5% |
| 5 | 743,061 | 22,723 | 3.1% | 791,283 | 33,788 | 4.3% |
| 6 | 991,910 | 32,685 | 3.3% | 1,048,234 | 47,820 | 4.6% |
| 7 | 438,479 | 15,818 | 3.6% | 473,316 | 23,706 | 5.0% |
| 8 | 310,708 | 9,812 | 3.2% | 341,938 | 15,397 | 4.5% |
| 9 | 163,721 | 3,857 | 2.4% | 181,436 | 6,993 | 3.9% |
| **Statewide** | **6,993,536** | **214,627** | **3.1%** | **7,375,005** | **311,385** | **4.2%** |

* Excludes Medicare and Medicaid recipients

# Demographics

The characteristics of a population may significantly affect that population's consumption of health care resources. The aging population also has a high correlation to heath care use rates. Michigan residents aged 45-64 years comprised 26.1 percent of the state's overall population compared to 25.0 percent for the same age group in the United States. Michigan's median age of 37.2 is slightly higher than the national median age of 36.4. Chart 1 provides a distribution of Michigan's population in 2006 by age group.

**Chart 1**



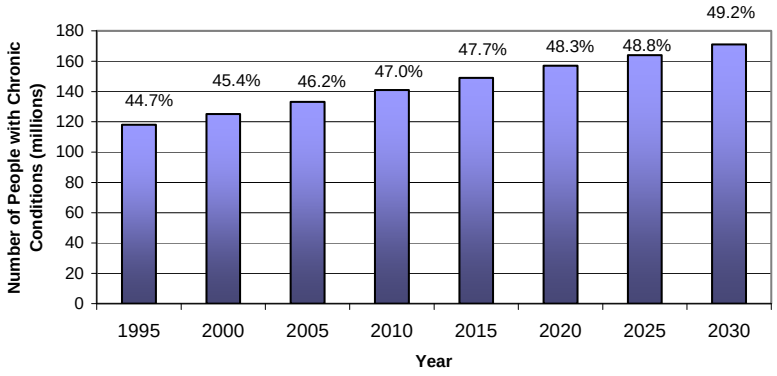

# Epidemiological Factors

The type of care rendered in the hospital setting is directly related to the health status of the population. Health status is affected by a number of different factors including demographics, the environment, prevalence of chronic disease and accidents/injuries as well as lifestyle choices.

While today's rates of chronic conditions are high, the proportion of the population affected by one or more chronic diseases is expected to grow. By 2025, chronic diseases will affect an estimated 164 million Americans – nearly half (49 percent) of the population.[1] Chart 2 illustrates rates of chronic conditions in the U.S. projected through 2030, when an estimated 49 percent of the population is expected to have one or more chronic conditions based on current trends.[1]

[1] "Chronic Conditions: Making the Case for Ongoing Care," Partnership for Solutions, September 2004 Update, available at: http://www.rwjf.org/files/research/ chronicbook2002.pdf.

**Chart 2**
**Increase in Chronic Conditions**
**1995, 2000 and 2005 Actual Rates Projected Through 2030[1]**




Michigan outranks most states in the percent of the adult population with chronic conditions such as:

- Obesity – Michigan ranked 10th in the nation, with an obesity rate of 28.2 percent compared to the national rate of 26.3 percent (2004-2007 average). An additional 36.1 percent of Michiganders are considered overweight, while only 35.7 percent are neither overweight nor obese. Obesity is a major risk factor for a number of chronic conditions including diabetes, hypertension, cardiovascular disease and cancer.[2]
- Diabetes – Michigan ranked 13th in the nation, with an adult diabetes rate of 8.8 percent compared to the national rate of 8.0 percent (2004-2007 average). [2]
- Hypertension – Michigan ranked 16th in the nation, with 28.6 percent of the population diagnosed with hypertension compared to the national rate of 27.8 percent (2003-2007 average).[2]
- Cancer- Michigan ranked 8th in the nation in the estimated number of new cases of cancer in 2008.[2]

Michigan also fares poorly with respect to the prevalence of lifestyle factors that contribute to chronic health conditions, such as smoking, lack of exercise and diet.[2] Chronic diseases, such as heart disease, stroke, cancer and diabetes are among the most prevalent, costly and preventable of all health problems.[1]

[2]"The State of Your Health: Michigan", http://healthyamericans.org., data through 2007.

Table 2 compares several health care indicators in Michigan's population to the population of the United States. Michigan scores better than the nation on 15 indicators while the nation as a whole scores higher on 14 other indicators.

**Table 2**
**Hospital Provider Class**

| Health Care Indicators | |
|---|---|
| ***Michigan is Better*** | ***United States is Better*** |
| Abortion | Adult Binge Drinking |
| Adequecy of Prenatal Care | Adult Obesity |
| Cervical Cancer Deaths | Asthma |
| Childhood Immunizations | Children's Blood Lead Levels |
| Childhood Injuries | Chlamydia |
| Colonoscopy/Sigmoidoscopy | Depression |
| Employer-Based Health Insurance Coverage | Diabetes Deaths (Underlying Cause) |
| HIV/AIDS New Cases | Gonorrhea |
| Mammography | Heart Disease Deaths |
| Prostate Cancer Deaths | Hepatitis C |
| Syphilis | Infant Mortality |
| Teen Pregnancy | Kidney Disease Deaths |
| Tobacco Use - Adolescents | Lung Cancer Deaths |
| Uninsured Residents | Tobacco Use - Adults |
| Unintentional Injuries | |

Source: Michigan Department of Community Health, Last Updated April 2007

Table 3 below illustrates the direction of several health indicators in the state that were determined by ten years of data when available.

**Table 3**
**Hospital Provider Class**

| Michigan Critical Health Indicators | |
|---|---|
| **Right Direction** | **Wrong Direction** |
| Abortions<br>Adolescent Alcohol and Drug Use<br>All Cancer Deaths<br>Breast Cancer Deaths<br>Cervical Cancer Deaths<br>Childhood Immunizations<br>Childhood Injuries<br>Children's Blood Lead Levels<br>Chlamydia<br>Colonoscopy/Sigmoidoscopy<br>Colorectal Cancer Deaths<br>Heart Disease Deaths<br>HIV/AIDS New Cases<br>Infant Mortality<br>Mammography<br>Older Adult Flu Shots<br>Prostate Cancer Deaths<br>Stroke Deaths<br>Syphilis<br>Teen Pregnancy<br>Tobacco Use - Adolescents | Adult Obesity<br>Diabetes Prevelance and Related Deaths<br>Employer-Based Health Insurance Coverage<br>Hepatitis C<br>Kidney Disease and Related Deaths<br>Pediatric Overweight |
| | **No Change** |
| | Adequacy of Prenatal Care<br>Adult Binge Drinking<br>Asthma<br>Chronic Lower Respiratory Disease Deaths<br>Gonorrhea<br>Lung Cancer Deaths<br>Nutrition/Diet<br>Physical Inactivity<br>Suicide<br>Tobacco Use - Adults<br>Uninsured Adults and Children<br>Unintentional Injuries |

Source: Michigan Department of Community Health, Last Updated August 2007.

# Economic Factors

## National Health Expenditures and Projections

National health expenditures rose 6.8 percent in 2006 and 6.7 percent in 2007.[3] Total 2007 health expenditures were projected to be almost $2.3 trillion, which translates to $7,439 per person, compared to actual per capita spending of $7,026 in 2006.[4]

[3] http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2006.pdf.
[4] http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf.

As a percentage of Gross Domestic Product (GDP), health care spending is projected to increase to 16.3 percent in 2007 from 16.0 percent in 2006. The healthcare spending share of GDP remained relatively stable in 2006 and 2007 as a result of relatively slower healthcare spending growth (since a recent peak of 9.1 percent in 2002), coupled with strong overall national economic growth during most of 2007.[4]

The hospital care component of national health expenditures rose 7.0 percent in 2006 and was projected to rise 7.5 percent in 2007, marking another year hospital spending was expected to outpace total personal health care. In 2007, hospital spending accounted for nearly one-third of total national health expenditures.[5]

## Inflationary Factors

As mentioned in the epidemiology section, the impact of chronic disease on health care costs cannot be ignored. Diagnoses related to obesity, diabetes and cardiovascular disease have consistently affected health care costs. The growth in chronic conditions and an aging population are increasing utilization of health services. At the same time, technological advances continue to provide new treatment options, which drive up the cost of care. For example, advanced techniques and technologies have revolutionized hip replacements, allowing more arthritis patients to consider treatments at an earlier stage than they had in the past.[6]

## Health Care Cost Containment

Governmental officials and policymakers agree that health care costs need to be controlled, but there is no consensus on the best way to control costs, and the debate continues on the federal and state levels. Some proposals include price controls and strict budgets on health care spending. Others favor free market competition, while public health advocates maintain that health care costs would decrease if all Americans adopted healthy lifestyles and subsequently needed less medical care.

Without agreement on a single solution, many approaches have been used to control health care spending, including provider pay-for-performance programs and promotion of healthy lifestyles. Programs like these have the potential to mitigate future cost increases and address some of the root cost drivers. Efforts to require public reporting of quality measures and to assess the appropriateness of new technologies will also make the health care system more accountable.

Hospitals themselves strive to contain costs by minimizing length of stay by utilizing other appropriate settings such as skilled nursing facilities or home health care when acute care is no longer necessary. Hospitals also strive for efficient use of equipment, facility capacity and human resources.



[5] http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2007.pdf.
[6] http://www.hipreplacement.com/DePuy/treatment/index.html.

## *Federal, State and Professional Regulation and Programs*

Several state and federal programs in effect during the reporting period impacted cost, quality and access to care. Michigan's Department of Consumer and Industry Services administers minimum standards for hospitals which must be met to obtain a state license as a hospital. BCBSM requires participating hospitals to have and maintain current state licensure to ensure quality facilities are available to its members.

Michigan's Certificate of Need (CON) Program strives to achieve a balance between cost, quality of and access to health care. The Certificate of Need Commission is an 11 member independent body appointed by the governor that approves CON Review Standards for determining need and ongoing quality assurance standards for health facilities and covered clinical services. BCBSM requires participating hospitals to comply with the CON requirements of the Michigan Public Health Code.

The Centers for Medicare and Medicaid Services has Conditions of Participation (CoP) and Conditions for Coverage (CfC) that health care organizations must meet to begin and continue to participate in the Medicare and Medicaid programs. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CoPs and CfCs apply to many facilities, including hospitals. In turn, one of BCBSM's qualification standards under the Hospitals Provider Class Plan is Medicare certification as a hospital.

The Michigan Health Information Network (MHIN) is an initiative of Michigan's governor, Jennifer Granholm. The goal of the MHIN is for medical records to move electronically with patients statewide, improving quality of care and reducing cost. Many functions of the health care system can be made more efficient by harnessing the power of technology.

# COST GOAL PERFORMANCE

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." This is expressed by the following formula:

$$\left[ \frac{(100 + I) * (100 + REG)}{100} \right] - 100$$

## PA 350 Cost Objectives

### Objective 1

Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions

### Objective 2

Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participating agreement

## Performance - Cost Goal and Objectives

BCBSM's two-year average percent change in payments per 1000 members was 21.8 percent for the hospital provider class (shown in Table 4). BCBSM did not meet the PA 350 cost goal of 4.6 percent. Although the hospital provider class did not independently achieve the cost goal, there is competent, material and substantial information to support a determination that the failure to achieve the goal was reasonable in accordance with Section 510(1)(b) of PA 350.

In 2007, utilization in both the inpatient and outpatient settings was the primary factor affecting the rise in payments per 1000 members. Although Traditional membership experienced another year of continued decline, utilization of benefits by existing members grew considerably. This trend resulted in fewer members over which to spread the cost of increased admissions and outpatient visits.

**Table 4**
**Hospital Provider Class**
**2005-2007 Performance against Cost Goal**

| | 2007 | 2006 | 2005 |
|---|---|---|---|
| **Payments** | | | |
| Inpatient and Outpatient | $433,278,189 | $510,956,936 | $708,524,619 |
| Per 1,000 members | $2,018,750 | $1,640,917 | $1,361,843 |
| % change | 23.0% | 20.5% | |
| **Members** | 214,627 | 311,385 | 520,269 |

| | | | |
|---|---|---|---|
| **Achievement of Cost Goal** | | *2007 percent of Total Payout reported to OFIR** | **13.3%** |
| **Two Year Average Percent Change:** | **21.8%** | | |
| **PA 350 Cost Goal** | **4.6%** | | |
| **Goal Not Met** | | *2007 ASC Business* | **36.9%** |

*Payout reported to OFIR includes Traditional claims for the hospital, MD, DO, clinical laboratory, fully licensed psychologist, podiatrist, chiropractor and ESRD provider classes. Traditional and PPO claims are included for the outpatient psychiatric care and substance abuse provider classes. Traditional, PPO and POS claims are included for the SNF, home health care, rehabilitation therapy, ASF, hospice, DME/P&O, ambulance, nurse specialists, HIT, dental, vision, hearing and pharmacy provider classes. See the technical notes section for more details.

The hospital provider class accounted for 13.3 percent of total BCBSM payments during this reporting period, a decrease from 2005 of 3.2 percent. Overall hospital cost performance showed the trend in hospital payments per 1000 members increasing, while membership continued to decline. The hospital payment per 1000 members increased approximately $660,000 or 48.2 percent from 2005 to 2007, while membership decreased approximately 306,000 members or 58.7 percent.

The cost section of this report provides a detailed analysis of factors impacting the increases in hospital costs for both the inpatient and outpatient settings. The tables provided in this discussion represent the most significant health care benefit categories such as major diagnostic categories, diagnosis related groupings and top diagnoses. Additional supporting data for each individual year is found in Appendix C.

**Table 4A**
**Hospital Provider Class**
**2005-2007 Cost, Use and Price Trends**
**Inpatient**

| | 2007 | 2006 | 2005 |
|---|---|---|---|
| **Payments** | | | |
| Total | $217,634,171 | $247,635,267 | $350,911,094 |
| Per 1,000 members | $1,014,011 | $795,270 | $674,480 |
| % change | 27.5% | 17.9% | |
| **Admissions** | | | |
| Total | 20,692 | 24,089 | 36,683 |
| Per 1,000 members | 96.41 | 77.36 | 70.51 |
| % change | 24.6% | 9.7% | |
| **Payment/ Admissions** | $10,517.79 | $10,280.01 | $9,566.04 |
| % change | 2.3% | 7.5% | |
| **Members** | 214,627 | 311,385 | 520,269 |

**Table 4B**
**Hospital Provider Class**
**2005 – 2007 Cost, Use and Price Trends**
**Outpatient**

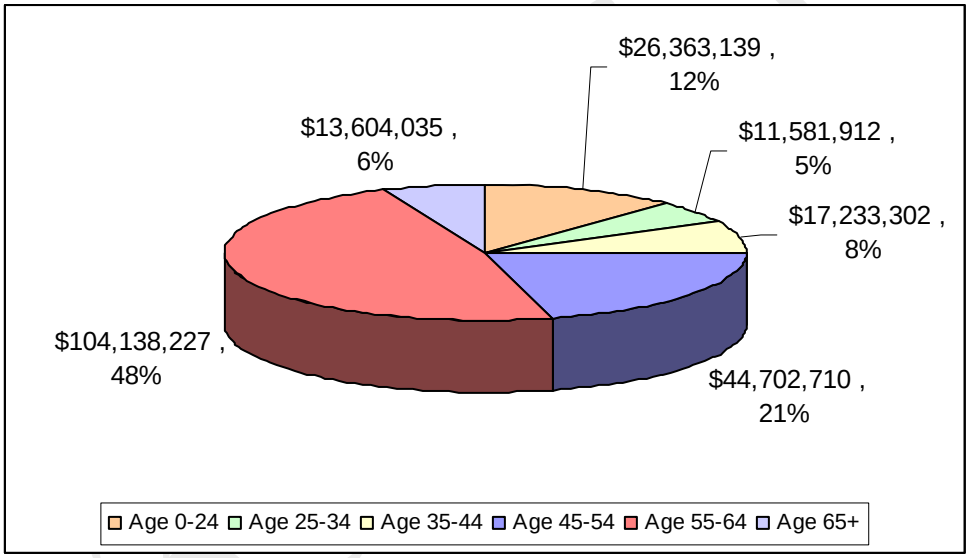
| | 2007 | 2006 | 2005 |
|---|---|---|---|
| **Payments** | | | |
| Total | $215,644,018 | $263,321,669 | $357,613,525 |
| Per 1,000 members | $1,004,738 | $845,647 | $687,363 |
| % change | 18.8% | 23.0% | |
| **Visit** | | | |
| Total | 526,658 | 675,396 | 1,005,813 |
| Per 1,000 members | 2,453.83 | 2,169.01 | 1,933.26 |
| % change | 13.1% | 12.2% | |
| **Payment/Visit** | $409.46 | $389.88 | $355.55 |
| % change | 5.0% | 9.7% | |
| **Members** | 214,627 | 311,385 | 520,269 |

# Inpatient Cost, Use and Price

Hospital inpatient costs increased $340,000 per 1000 members, or an average of 22.7 percent during this reporting period. The cost increase was the result of a significant rise in admissions that averaged 17.5 percent. As membership decreased and utilization increased during the reporting period, the percentage of patients using benefits increased from 6.0 percent in 2006 to 7.5 percent in 2007.

As shown in Chart 3, the age group responsible for 54 percent of inpatient payout during 2007 was members aged 55 years and older.

**Chart 3**
**Hospital Provider Class**
**2007 Inpatient Payments by Age**




Worldwide, trends in aging show the average life span is expected to increase, and with the growing number of older adults there is an expectation of increased demands on the public health system and medical and social services.[7]

Increased life expectancies have already impacted the number of chronic conditions, injuries and disabilities that require medical treatment. The next section examines the distribution of inpatient payments among each of the major diagnostic categories and their impact on overall costs.

[7] www.cdc.gov/mmwr/preview/mmwrhtml/mm5206a2.htm.

# Major Diagnostic Category

**Table 5**
**Hospital Provider Class**
**2005-2007 Inpatient Payments by Major Diagnostic Category**

| Inpatient Hospital by Major Diagnostic Catergory | Two year average rate of change Per 1000 Members | | | | 2007-2005 Payments | 2007-2005 Days/Svcs | 2007-2005 Adm | 2007-2005 Avg Pmt/Day | 2007-2005 Avg Pmt/Adm | Pct to Total Payout |
|---|---|---|---|---|---|---|---|---|---|---|
| | Payments | Days | Adm | Pmt/Adm | | | | | | |
| Circulatory System | 14.2% | 8.4% | 7.1% | 6.7% | $ 159,277,983 | 37,959 | 10,009 | $ 4,196 | $ 15,913 | 19.5% |
| Musculorskeletal | 27.2% | 17.2% | 16.1% | 9.5% | $ 147,573,202 | 38,882 | 11,016 | $ 3,795 | $ 13,396 | 18.1% |
| Digestive System | 29.5% | 17.7% | 15.3% | 12.4% | $ 72,333,666 | 35,841 | 7,693 | $ 2,018 | $ 9,403 | 8.9% |
| Respiratory System | 22.7% | 12.7% | 8.4% | 13.4% | $ 66,191,534 | 31,544 | 6,759 | $ 2,098 | $ 9,793 | 8.1% |
| Pregnancy | -5.4% | 4.1% | 2.1% | -7.9% | $ 45,269,571 | 27,081 | 10,587 | $ 1,672 | $ 4,276 | 5.5% |
| Nervous System | 34.2% | 20.0% | 15.0% | 16.7% | $ 43,728,566 | 15,475 | 3,346 | $ 2,826 | $ 13,069 | 5.4% |
| Nutritional Disease | 24.2% | 16.1% | 14.6% | 8.6% | $ 33,698,139 | 11,114 | 3,396 | $ 3,032 | $ 9,923 | 4.1% |
| Factors Influencing Health Status | 26.3% | 18.7% | 12.2% | 12.2% | $ 31,433,306 | 19,736 | 2,917 | $ 1,593 | $ 10,776 | 3.9% |
| Female Reproductive Sys | 14.7% | 4.0% | 4.1% | 9.9% | $ 30,877,552 | 10,371 | 4,351 | $ 2,977 | $ 7,097 | 3.8% |
| Hepatobiliary Sys/Pancreas | 28.1% | 17.8% | 19.3% | 7.3% | $ 23,384,781 | 11,019 | 2,110 | $ 2,122 | $ 11,083 | 2.9% |
| Mental Disorders | 31.2% | 22.6% | 22.5% | 7.1% | $ 23,384,181 | 27,771 | 4,687 | $ 842 | $ 4,989 | 2.9% |
| Kidney/Urinary Tract | 24.4% | 15.4% | 14.7% | 8.4% | $ 22,727,783 | 9,356 | 2,488 | $ 2,429 | $ 9,135 | 2.8% |
| Neoplasms | 22.5% | 11.6% | 7.6% | 13.3% | $ 21,439,507 | 7,879 | 830 | $ 2,721 | $ 25,831 | 2.6% |
| Newborns in Perinatal Period | 30.9% | 61.8% | 386.7% | -35.8% | $ 21,282,171 | 13,765 | 2,936 | $ 1,546 | $ 7,249 | 2.6% |
| Injury Poisoning | 34.9% | 24.3% | 22.9% | 9.3% | $ 18,640,254 | 9,329 | 1,932 | $ 1,998 | $ 9,648 | 2.3% |
| Infectious Disease | 49.1% | 26.1% | 26.3% | 17.8% | $ 18,013,188 | 9,666 | 1,329 | $ 1,864 | $ 13,554 | 2.2% |
| Skin & Subcutaneous Disease | 22.1% | 14.6% | 13.0% | 8.1% | $ 12,332,013 | 7,288 | 1,965 | $ 1,692 | $ 6,276 | 1.5% |
| Disease of the Blood | 28.6% | 20.6% | 19.3% | 7.7% | $ 7,723,372 | 3,954 | 899 | $ 1,953 | $ 8,591 | 0.9% |
| Male Reproductive Sys | 31.0% | 10.5% | 12.6% | 16.1% | $ 6,929,193 | 1,692 | 779 | $ 4,095 | $ 8,895 | 0.8% |
| Disease of ENT | 16.6% | 7.7% | 9.0% | 7.9% | $ 6,678,289 | 2,695 | 966 | $ 2,478 | $ 6,913 | 0.8% |
| Burns | 75.0% | 32.0% | 3.3% | 68.4% | $ 948,986 | 269 | 52 | $ 3,528 | $ 18,250 | 0.1% |
| Alcohol/Drug Abuse | 52.0% | 34.3% | 37.3% | 11.1% | $ 928,716 | 1,017 | 242 | $ 913 | $ 3,838 | 0.1% |
| Disease of the Eye | -20.2% | -18.8% | -2.8% | -16.4% | $ 509,574 | 293 | 84 | $ 1,739 | $ 6,066 | 0.1% |
| Other | 371.8% | 348.8% | 259.8% | 27.5% | $ 469,343 | 191 | 65 | $ 2,457 | $ 7,221 | 0.1% |
| Human Immunodeficiency Virus Infec | 130.3% | 142.0% | 110.2% | 10.3% | $ 405,658 | 250 | 26 | $ 1,623 | $ 15,602 | 0.0% |
| **Total** | **22.7%** | **16.4%** | **17.2%** | **4.9%** | **$ 816,180,533** | **334,437** | **81,464** | **$ 2,440** | **$ 10,019** | **100%** |

Major diagnostic categories identify the main reason for an inpatient encounter. They allow for a broad definition of a patient's experience, and they are defined by the primary diagnosis determined during a patient's admission.

As shown in Table 5, the circulatory, musculoskeletal, digestive and respiratory MDCs three-year payout accounted for 55 percent or $445 million of total inpatient payments.

- Circulatory conditions accounted for 19.5 percent of total inpatient payout, and had an average payment per 1000 member increase of 14.2 percent. The increase was impacted almost equally between price and use which increased 6.7 percent and 7.1 percent, respectively. Disorders of the circulatory system generally result in diminished flow of blood and diminished oxygen exchange to the tissues potentially resulting in conditions such as heart attack and stroke.[8] According to the American Heart Association, nearly 70% of the US population has some level of heart disease.[9]

[8] http://www.infoplease.com/ce6/sci/A0857356.html.
[9] http://cardio360.com/heart-disease-statistics.html.

- Musculoskeletal conditions had the second highest payout at 18.1 percent of total inpatient payments. The number of admissions per 1000 members for this category increased an average of 16.1 percent, while price increased an average of 9.5 percent. Musculoskeletal conditions cost the United States economy more than $215 billion a year, and one in every 7 Americans has a musculoskeletal impairment that limits or decreases their ability to function at home, work or play. This percentage is expected to grow as the population increases in age.[10]

- Payments per 1000 for digestive conditions increased approximately 30 percent during 2007. Conditions for this population included diagnoses such as bowel procedures, gastrointestinal disorders, hernias and appendectomies. Thirty percent of Americans suffer a gastroenterological illness each year, resulting in over 8 million hospital admissions and 30 million doctor visits.[11] Although digestive disorders can affect people of any age, many digestive disorders occur more frequently in older individuals. In fact, nearly 40% of all older adults have one or more symptoms of digestive disorders each year, largely due to changes that occur in the digestive tract with age.[12]

- Respiratory conditions had an increased payment per 1000 of 22.7 percent. Conditions afflicting members during 2007 included respiratory failure, pneumonia, lung cancer and COPD. In 2007, the cost to the nation for chronic obstructive pulmonary disease or COPD was approximately $42.6 billion, including $26.7 billion in direct health care expenditures, $8.0 billion in indirect morbidity and $7.9 billion in indirect mortality costs.[13]

## Diagnostic Related Groups

**Table 6**
**Hospital Provider Class**
**2007-2005 Inpatient Payments by Top 10 Diagnostic Related Groups**

| Diagnositc Related Group | Two year average rate of change Per 1000 Members | | | | 2005-2007 Payments | 2005-2007 Days | 2005-2007 Adm | 2005-2007 Avg Pmt/Day | 2005-2007 Avg Pmt/Case | Pct to Total Payout |
|---|---|---|---|---|---|---|---|---|---|---|
| | Payments | Days | Admissions | Pmt/Adm | | | | | | |
| Major Joint Replacement | 246.1% | 232.7% | 227.3% | 8.2% | $ 33,771,215 | 6,352 | 1,949 | $ 5,317 | $ 17,327 | 4.1% |
| Ecmo Or Trach W Mv 96+Hrs W Maj O.R. | 59.6% | 35.6% | 53.3% | 4.4% | $ 16,010,919 | 4,129 | 105 | $ 3,878 | $152,485 | 2.0% |
| Vaginal Delivery W/O Complicating Diagnoses | -16.7% | 4.8% | 1.8% | -17.9% | $ 15,833,616 | 9,940 | 5,138 | $ 1,593 | $ 3,082 | 1.9% |
| Uterine & Adnexa Proc For Non-Malignancy W/O Cc | 7.9% | -4.5% | -0.1% | 8.0% | $ 14,104,038 | 4,665 | 2,230 | $ 3,023 | $ 6,325 | 1.7% |
| O.R. Procedures For Obesity | 12.2% | -3.9% | 7.6% | 4.5% | $ 13,813,320 | 2,459 | 1,029 | $ 5,617 | $ 13,424 | 1.7% |
| Cesarean Section W/O Cc | 0.0% | 5.5% | 5.8% | -6.2% | $ 13,366,960 | 7,005 | 2,244 | $ 1,908 | $ 5,957 | 1.6% |
| Percutaneous Cardiovascular W Drug-Eluting Stent | 207.7% | 190.2% | 209.0% | 3.2% | $ 12,685,684 | 1,251 | 910 | $ 10,140 | $ 13,940 | 1.6% |
| Rehabilitation | 10.6% | 6.0% | 3.0% | 7.9% | $ 12,173,830 | 10,005 | 832 | $ 1,217 | $ 14,632 | 1.5% |
| Trach W Mv 96+Hrs W/O Maj O.R. | 36.3% | 1.2% | 25.6% | 10.7% | $ 8,729,037 | 2,573 | 94 | $ 3,393 | $ 92,862 | 1.1% |
| Percutaneous Cardiovascular W Drug-Eluting Stent | 222.4% | 214.7% | 208.5% | 5.6% | $ 8,091,602 | 1,171 | 421 | $ 6,910 | $ 19,220 | 1.0% |
| **Top 10** | **47.0%** | **19.5%** | **21.1%** | **45.2%** | **$ 148,580,221** | **49,550** | **14,952** | | **$ 9,937** | **18.2%** |
| Top 50 | 36.8% | 19.9% | 26.6% | 8.0% | $ 336,195,390 | 117,853 | 31,036 | $ 2,853 | $ 10,832 | 41% |
| **Grand Total** | **22.7%** | **16.4%** | **17.2%** | **4.9%** | **$ 816,180,532** | **334,437** | **81,464** | **$ 2,440** | **$ 10,019** | **100%** |

[10] Medical Reporter.health.org/tmr1099/orthopaedics.html.
[11] http://broadmedical.org/asset/120-aga%20fellowship%207-24-07.pdf.
[12] http://www.johnshopkinshealthalerts.com/reports/digestive_health/871-1.html.
[13] http://www.qualitycarepartners.com/respdiseaseEmp.html.

In the process of reviewing the MDC cost and use experience, it is also meaningful to examine diagnosis codes. Table 6 shows the top 10 diagnostic related groups by payout. Diagnostic related groupings (DRG) are a system for classifying inpatient care; the purpose is to provide a framework for specifying case mix. BCBSM's top 10 diagnostic related groups accounted for approximately $149 million or 18.2 percent of total inpatient payout, and had an average increase in payments per 1000 members of 47 percent. Joint replacement, ECMO or tracheotomy, child birth and obesity conditions were among the top five DRGs by payout. These DRGs as well as many in the Top 50 (shown in Appendix C) reflect the circulatory, musculoskeletal, digestive and respiratory MDCs described in the previous section as drivers in the increased hospital inpatient trend.

Limb and joint replacement accounted for the highest payout for inpatient cost with 4.1 percent of the total payments. The average payment per admission for this service was $17,327. Joint replacement surgery is on the rise, and according to findings presented at the annual meeting of the American Academy of Orthopaedic Surgery, hip and knee replacements will increase by 174 percent by 2030.[14] Joint replacement is very successful in improving quality of life, and as people become more aware of the successes of these procedures, studies suggest that the demand for these surgeries may overwhelm supply. In addition, as the number of hip and knee replacement surgeries increase, so will the need for rehabilitation services.

In intensive care medicine, extracorporeal membrane oxygenation (ECMO) is a technique providing both cardiac and respiratory support oxygen to patients whose heart and lungs are so severely damaged that they can no longer serve their function. ECMO is most commonly used in NICUs (neonatal intensive care units), for newborns in pulmonary distress.[15] During this reporting period, the DRG for ECMO was the second highest payout with an increase in payments per 1000 members of nearly 60 percent; almost entirely due to a rise in utilization of 53 percent.

Operating room procedures for obesity ranked as the fifth highest payout by DRG and had an average payment per admission of $13,424. This DRG specifically relates to bariatric surgery which is a surgical procedure for obese patients in their effort to achieve extreme weight loss. Overall, obesity is a major risk factor for a number of chronic conditions including diabetes, hypertension, cardiovascular disease and cancer.[2] Lastly, the cost of direct medical care of this condition for Michigan adults has been conservatively estimated at $58 million per year.[16]

## Outpatient Cost, Use and Price

Total three-year payout for outpatient hospital care was $837 million during this reporting period. The two-year average outpatient increase in payments per 1000 members was 20.9 percent, as a result of a 12.7 percent rise in utilization and a 7.3 percent increase in payment per service.

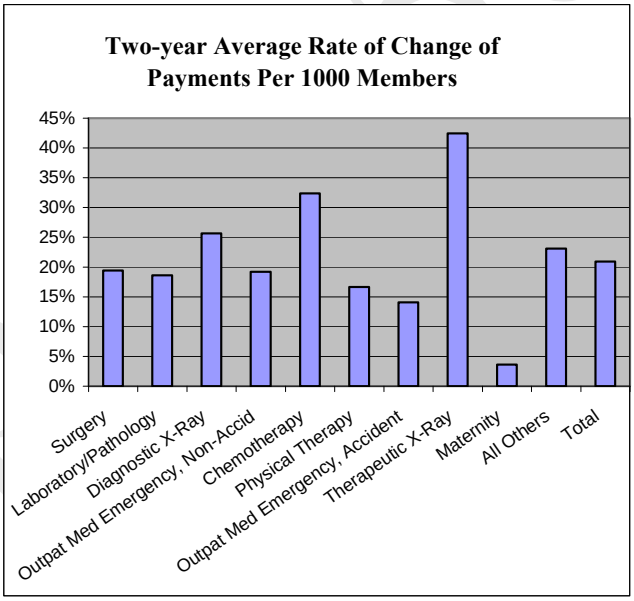
[14] www.medscape.com/viewarticle/528464.
[15] http://en.wikipedia.org/wiki/ECMO.
[16] www.michigan.gov/mdch/0,1607,7-132-2940-2955-21222-105110.

Similar to inpatient, members aged 55 years and older accounted for the nearly 50 percent of total payout (Appendix C), and the percentage of patients using outpatient benefits increased from approximately 70 to 78 percent in 2006 and 2007, respectively.

## Type of Service

**Table 7**
**Hospital Provider Class**
**2005-2007 Outpatient Payments by Type of Service**

| Type of Service | Two-year average rate of change Payments Per 1000 Members | Services Per 1000 Members | Payment Per Service | Three-year Payout | % of Total Payout |
|---|---|---|---|---|---|
| Surgery | 19.4% | 12.2% | 6.4% | $ 260,219,372 | 31.1% |
| Laboratory/Pathology | 18.6% | 13.1% | 4.8% | $ 163,993,462 | 19.6% |
| Diagnostic X-Ray | 25.6% | 15.3% | 9.1% | $ 155,872,058 | 18.6% |
| Outpat Med Emergency, Non-Accid | 19.2% | 10.8% | 7.6% | $ 97,853,359 | 11.7% |
| Chemotherapy | 32.4% | 21.9% | 8.0% | $ 39,718,792 | 4.7% |
| Physical Therapy | 16.7% | 10.8% | 5.2% | $ 42,568,375 | 5.1% |
| Outpat Med Emergency, Accident | 14.1% | 6.1% | 7.5% | $ 28,292,587 | 3.4% |
| Therapeutic X-Ray | 42.5% | 29.6% | 23.6% | $ 25,730,475 | 3.1% |
| Maternity | 3.6% | 5.0% | -1.3% | $ 11,836,025 | 1.4% |
| All Others | 23.1% | 4.6% | 17.2% | $ 10,494,706 | 1.3% |
| **Total** | **20.9%** | **12.7%** | **7.3%** | **$ 836,579,212** | **100.0%** |



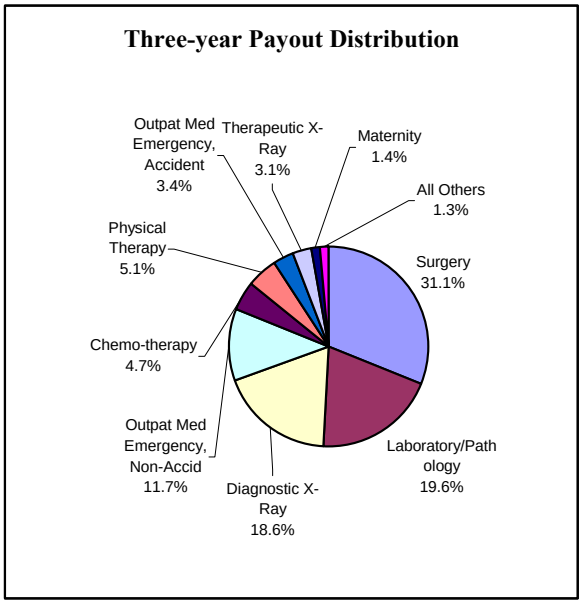



Table 7 shows that surgery, laboratory/pathology and diagnostic radiology accounted for 70 percent of total outpatient payments. In many respects, these top three types of service are often used in conjunction with one another to provide patient care. For example, many times, surgical procedures are coupled with laboratory/pathology services as physicians order a variety of blood and imaging tests to diagnose and subsequently treat a presented illness.

As described in the upcoming sections, review of the surgical and diagnostic radiology types of service lead to the realization that the traditional hospital membership is an older, potentially less healthy population. The outpatient diagnoses for this population included cancer diagnoses and screenings, circulatory conditions including chest pain, hypertension, atrial fibrillation and coronary atherosclerosis and musculoskeletal conditions such as joint pain, arthritis, knee and shoulder problems and lumbago. These conditions were recurring themes throughout analysis of the hospital cost section from the broadly defined type of service categories to the detailed diagnostic code descriptions.

## Outpatient Cost by Major Diagnostic Category

**Table 8**
**Hospital Provider Class**
**2005-2007 Outpatient Payments by Major Diagnostic Category**

| Outpatient Hospital by Major Diagnostic Category | Two year average rate of change Per 1000 Members | | | 2005-2007 Payments | 2005-2007 Visits | Avg Pmt/Vst | Pct of Total | |
|---|---|---|---|---|---|---|---|---|
| | Payments | Visits | Pmt/Vst | | | | Payout | Days |
| Musculorskeletal | 17.5% | 11.4% | 5.5% | $ 160,720,850 | 428,294 | $ 375 | 19.2% | 14.0% |
| Digestive System | 17.5% | 11.9% | 5.0% | $ 96,836,613 | 283,890 | $ 341 | 11.6% | 9.3% |
| Factors Influencing Health Status | 25.8% | 14.6% | 9.8% | $ 87,537,229 | 522,023 | $ 168 | 10.5% | 17.0% |
| Respiratory System | 15.1% | 9.4% | 5.3% | $ 65,213,180 | 183,540 | $ 355 | 7.8% | 6.0% |
| Circulatory System | 19.9% | 16.0% | 3.4% | $ 65,124,066 | 203,361 | $ 320 | 7.8% | 6.6% |
| Skin & Subcutaneous Disease | 28.3% | 13.3% | 13.3% | $ 61,562,519 | 201,723 | $ 305 | 7.4% | 6.6% |
| Kidney/Urinary Tract | 20.4% | 13.8% | 5.9% | $ 43,821,976 | 176,146 | $ 249 | 5.2% | 5.7% |
| Disease of ENT | 14.1% | 5.9% | 7.8% | $ 37,766,902 | 144,979 | $ 260 | 4.5% | 4.7% |
| Nutritional Disease | 23.5% | 14.0% | 8.3% | $ 34,461,566 | 343,402 | $ 100 | 4.1% | 11.2% |
| Female Reproductive Sys | 19.3% | 8.7% | 9.8% | $ 32,882,429 | 106,092 | $ 310 | 3.9% | 3.5% |
| Nervous System | 19.0% | 11.5% | 6.8% | $ 31,429,751 | 67,518 | $ 466 | 3.8% | 2.2% |
| Neoplasms | 24.3% | 17.5% | 5.9% | $ 29,384,672 | 65,686 | $ 447 | 3.5% | 2.1% |
| Hepatobiliary Sys/Pancreas | 21.4% | 14.3% | 6.2% | $ 18,813,600 | 46,398 | $ 405 | 2.2% | 1.5% |
| Disease of the Eye | 21.4% | 10.0% | 10.3% | $ 15,667,233 | 28,988 | $ 540 | 1.9% | 0.9% |
| Disease of the Blood | 40.8% | 12.4% | 25.2% | $ 14,958,666 | 99,880 | $ 150 | 1.8% | 3.3% |
| Male Reproductive Sys | 34.6% | 14.6% | 17.3% | $ 12,730,573 | 33,077 | $ 385 | 1.5% | 1.1% |
| Pregnancy | 3.6% | 2.4% | 1.2% | $ 7,722,287 | 36,687 | $ 210 | 0.9% | 1.2% |
| Injury Poisoning | 22.4% | 10.2% | 11.1% | $ 6,765,124 | 22,945 | $ 295 | 0.8% | 0.7% |
| Infectious Disease | 10.4% | 4.2% | 6.1% | $ 3,733,403 | 31,703 | $ 118 | 0.4% | 1.0% |
| Mental Disorders | 31.0% | 15.5% | 13.3% | $ 3,485,611 | 21,102 | $ 165 | 0.4% | 0.7% |
| Alcohol/Drug Abuse | 48.8% | 18.4% | 23.9% | $ 1,027,944 | 4,913 | $ 209 | 0.1% | 0.2% |
| Newborns in Perinatal Period | 73.6% | 7.8% | 63.3% | $ 410,145 | 3,351 | $ 122 | 0.0% | 0.1% |
| Burns | 8.8% | 8.5% | 0.3% | $ 409,114 | 1,660 | $ 246 | 0.0% | 0.1% |
| Human Immunodeficiency Virus | 74.8% | 29.9% | 34.3% | $ 313,851 | 1,791 | $ 175 | 0.0% | 0.1% |
| Other | 25.7% | 5.8% | 18.7% | $ 684,565 | 1,851 | $ 370 | 0.1% | 0.1% |
| Unknown | 590.6% | 338.6% | 31.9% | $ 3,115,341 | 5,635 | $ 553 | 0.4% | 0.2% |
| **Total** | **20.9%** | **12.7%** | **7.3%** | **$ 836,579,212** | **3,066,635** | **$ 273** | **100.0%** | **100.0%** |

Table 8 shows the distribution of hospital outpatient costs, utilization and price by major diagnostic category. The majority of the categories had an average payment increase that was greater than 10 percent. Musculoskeletal and digestive disorders accounted for 19.2 percent and 11.6 percent of total payout, respectively.

The payout for musculoskeletal services was approximately $160 million, and had an average increase in payments per 1000 members of 17.5 percent, as a result of an 11.4 percent increase in utilization and a 5.5 percent increase in price. The increase in utilization was the significant factor in both 2006 and 2007 (Appendix C). Musculoskeletal conditions include back pain, joint pain, arthritic disorders and sprains and tears which are all conditions associated with physical activity. As the population becomes more active and/or ages, risk associated with physical activity will increase.

Digestive disorders ranked second in terms of total payout and had an average increase in payments per 1000 members of 17.5 percent primarily due to increased visits. The most common diagnoses by payment were abdominal pain, hernia and colon disorders and cancer. These are all conditions that may be impacted by a member's diet, weight, level of stress and lifestyle choices.

# Top 50 Diagnosis

## Table 9
## Hospital Provider Class
## 2005-2007 Outpatient Payments by Top 50 Diagnoses

| Outpatient Hospital by Top 50 Diagnoses | Two year average rate of change Per 1000 Members | | | 2005-2007 Payments | 2005-2007 Visits | Avg Pmt/Vst | % of Total Payout |
|---|---|---|---|---|---|---|---|
| | Payments | Visits | Pmt/Vst | | | | |
| Chest Pain Nos | 9.0% | 4.8% | 4.2% | $ 17,810,974 | 20,273 | $ 879 | 2.1% |
| Malign Neopl Breast Nos | 39.7% | 19.1% | 17.0% | $ 16,665,016 | 19,371 | $ 860 | 2.0% |
| Chest Pain Nec | 14.5% | 8.9% | 5.1% | $ 13,108,179 | 8,458 | $ 1,550 | 1.6% |
| Crnry Athrscl Natve Vssl | 26.6% | 12.7% | 12.6% | $ 11,070,479 | 6,986 | $ 1,585 | 1.3% |
| Screen Mammogram Nec | 32.5% | 14.0% | 16.2% | $ 9,818,706 | 100,008 | $ 98 | 1.2% |
| Antineoplastic Chemo Enc | 478.7% | 387.9% | 6.2% | $ 9,416,421 | 2,945 | $ 3,197 | 1.1% |
| Lumbago | 19.2% | 9.6% | 8.8% | $ 9,022,278 | 17,032 | $ 530 | 1.1% |
| Malign Neopl Prostate | 40.0% | 18.3% | 19.2% | $ 8,835,722 | 9,510 | $ 929 | 1.1% |
| Benign Neoplasm Lg Bowel | 16.5% | 10.3% | 5.7% | $ 7,998,535 | 10,437 | $ 766 | 1.0% |
| Abdmnal Pain Unspcf Site | 23.1% | 15.1% | 6.9% | $ 7,956,146 | 22,558 | $ 353 | 1.0% |
| Headache | 19.5% | 10.4% | 8.3% | $ 7,176,059 | 11,909 | $ 603 | 0.9% |
| Calculus Of Kidney | 20.4% | 15.9% | 3.9% | $ 6,999,952 | 9,898 | $ 707 | 0.8% |
| Calculus Of Ureter | 12.2% | 6.4% | 5.5% | $ 6,475,272 | 4,161 | $ 1,556 | 0.8% |
| Hypertension Nos | 19.5% | 13.0% | 5.9% | $ 6,000,728 | 42,834 | $ 140 | 0.7% |
| Hyperlipidemia Nec/Nos | 14.1% | 8.0% | 5.6% | $ 5,877,932 | 77,996 | $ 75 | 0.7% |
| Oth Lymp Unsp Xtrndl Org | 15.0% | 8.5% | 6.5% | $ 5,734,930 | 5,290 | $ 1,084 | 0.7% |
| Cholelith W Cholecys Nec | 19.9% | 12.4% | 7.1% | $ 5,560,910 | 1,571 | $ 3,540 | 0.7% |
| Screen Malig Neop-Colon | 45.3% | 34.4% | 8.2% | $ 5,391,181 | 9,442 | $ 571 | 0.6% |
| Mal Neo Bronch/Lung Nos | 14.3% | 10.8% | 3.4% | $ 4,900,759 | 5,386 | $ 910 | 0.6% |
| Regional Enteritis Nos | 25.2% | 11.2% | 12.9% | $ 4,552,966 | 4,062 | $ 1,121 | 0.5% |
| Joint Pain-L/Leg | 23.6% | 13.5% | 8.9% | $ 4,363,729 | 11,626 | $ 375 | 0.5% |
| Dmii Wo Cmp Nt St Uncntr | 25.2% | 20.6% | 3.8% | $ 4,293,914 | 49,059 | $ 88 | 0.5% |
| Cervicalgia | 24.4% | 15.7% | 7.5% | $ 4,235,291 | 7,922 | $ 535 | 0.5% |
| Tear Med Menisc Knee-Cur | 19.7% | 6.4% | 12.4% | $ 3,981,574 | 2,843 | $ 1,400 | 0.5% |
| Rheumatoid Arthritis | 28.3% | 17.3% | 9.2% | $ 3,947,912 | 8,544 | $ 462 | 0.5% |
| Atrial Fibrillation | 96.5% | 29.3% | 51.8% | $ 3,945,098 | 20,965 | $ 188 | 0.5% |
| Excessive Menstruation | 15.6% | 11.5% | 3.4% | $ 3,943,453 | 4,630 | $ 852 | 0.5% |
| Pain In Limb | 20.8% | 12.3% | 7.4% | $ 3,898,385 | 14,192 | $ 275 | 0.5% |
| Dizziness And Giddiness | 24.0% | 10.2% | 12.3% | $ 3,896,215 | 6,813 | $ 572 | 0.5% |
| Unilat Inguinal Hernia | 7.6% | 2.5% | 4.8% | $ 3,871,562 | 2,030 | $ 1,907 | 0.5% |
| Rotator Cuff Synd Nos | 11.4% | 4.0% | 7.1% | $ 3,854,053 | 2,656 | $ 1,451 | 0.5% |
| Abdmnal Pain Oth Spcf St | 15.2% | 8.9% | 5.9% | $ 3,809,934 | 5,446 | $ 700 | 0.5% |
| Syncope And Collapse | 25.2% | 11.6% | 12.2% | $ 3,776,474 | 5,102 | $ 740 | 0.5% |
| Anemia Nos | 29.8% | 11.8% | 16.1% | $ 3,736,451 | 25,718 | $ 145 | 0.4% |
| Joint Pain-Shlder | 28.0% | 15.7% | 10.7% | $ 3,645,836 | 8,142 | $ 448 | 0.4% |
| Malignant Neo Colon Nos | 7.7% | 20.6% | -10.8% | $ 3,552,881 | 3,311 | $ 1,073 | 0.4% |
| Dvrtclo Colon W/O Hmrhg | 12.3% | 5.1% | 7.0% | $ 3,451,104 | 5,195 | $ 664 | 0.4% |
| Respiratory Abnorm Nec | 18.2% | 9.6% | 7.5% | $ 3,413,584 | 5,613 | $ 608 | 0.4% |
| Malign Neopl Ovary | 63.4% | 37.0% | 16.8% | $ 3,361,281 | 4,580 | $ 734 | 0.4% |
| Screen Mal Neop-Cervix | 27.8% | 14.4% | 11.5% | $ 3,329,889 | 70,660 | $ 47 | 0.4% |
| Sprain Rotator Cuff | 32.3% | 14.5% | 15.3% | $ 3,326,757 | 2,465 | $ 1,350 | 0.4% |
| Malaise And Fatigue Nec | 18.2% | 12.1% | 5.4% | $ 3,247,773 | 23,571 | $ 138 | 0.4% |
| Malign Neopl Breast Nec | 63.3% | 25.0% | 29.7% | $ 3,187,001 | 4,532 | $ 703 | 0.4% |
| Other Lung Disease Nec | 34.8% | 21.6% | 10.7% | $ 3,076,417 | 4,893 | $ 629 | 0.4% |
| Urin Tract Infection Nos | 21.5% | 14.8% | 6.0% | $ 3,027,231 | 34,408 | $ 88 | 0.4% |
| Mal Neo Breast Up-Outer | 28.0% | 18.6% | 20.6% | $ 2,955,532 | 1,643 | $ 1,799 | 0.4% |
| Obstructive Sleep Apnea | 294.1% | 298.6% | -0.7% | $ 2,940,936 | 2,601 | $ 1,131 | 0.4% |
| Mult Myelm W/O Remission | 34.3% | 32.8% | 0.9% | $ 2,812,511 | 3,131 | $ 898 | 0.3% |
| End Stage Renal Disease | 317.0% | 247.7% | 25.1% | $ 2,753,976 | 941 | $ 2,927 | 0.3% |
| Cataract Nos | 33.8% | 24.4% | 7.5% | $ 2,677,495 | 1,328 | $ 2,016 | 0.3% |
| Top 50 Total | 28.8% | 14.8% | 12.2% | $ 276,687,392 | 734,687 | $ 377 | 33.1% |
| **GRAND TOTAL** | **20.9%** | **12.7%** | **7.3%** | **$ 836,579,212** | **2,207,867** | **$ 379** | **100.0%** |

As shown in Table 9, the top 50 diagnoses represented approximately $277 million or 33.1 percent of total outpatient payments. The highest ranking by payout was for chest pain, a circulatory condition. The average payment increase per 1000 members for this service was 9.0 percent due to an average increase in use of 4.8 percent and a rise in price of 4.2 percent. Circulatory disorders include conditions such as chest pain, coronary artherosclerosis, atrial fibrillation and hypertension.

# Cost Containment Programs

The health care industry has responded to chronic disease trends with a shift toward disease management programs as a means of controlling cost. The purpose of disease management is to empower participants so they can better manage and improve their own health. BCBSM has also broadened its scope of medical care management design. BCBSM no longer directs all of its attention to provider costs and provider utilization, but has added member-centric programs. Highlights of BCBSM's cost containment programs are described below:

## Member-focused Health Management

### BlueHealthConnection®

BCBSM's BlueHealthConnection® is an integrated care management program, addressing member needs relative to chronic conditions and health care decision support. Members have access to important clinical assistance and educational tools to help make their health care decisions.

BlueHealthConnection nurses help patients manage symptoms of minor illnesses or injuries, provide general information such as tips for healthy lifestyles or side effects of prescription drugs, manage chronic diseases, discuss treatment options, support weight loss and tobacco cessation efforts, and provide case management for the sickest one percent of the population. BlueHealthConnection nurses also advocate for the appropriate care setting for recommended services.

The BCBSM BlueHealthConnection Guided Self-Management Satisfaction Survey is an annual survey used to measure users' overall satisfaction with BlueHealthConnection.[17] In 2007, overall satisfaction with BlueHealthConnection remained high (90% satisfaction) and identical to 2005 and 2006. Recommendations from the 2007 survey were very positive with an emphasis on:

- Continuing to promote and expand the BlueHealthConnection offerings.
- Expansion of the information available through BlueHealthConnection.
- Continuing to increase the amount of information that is available over the Internet (versus printed material).

With BlueHealthConnection, BCBSM has gone beyond traditional disease management and achieved a whole-person approach to care management. Members' needs are met by helping

[17] http://blueslink.bcbsm.com/spm/SP/Surveys/2007%20BHC%20Guided%20Self-Mgmt%20-%20Report.pdf.

them cope with health conditions they and their loved ones are struggling to manage. This program allows BCBSM to become their health care partner and single source for health management information.

Member awareness of BlueHealthConnection is promoted through online tools on the BCBSM website as well as materials that can be displayed and distributed to members by their employers. In addition, BCBSM also has a targeted outreach program that uses claims data to identify members who are at risk for specific medical conditions. Lastly, providers are informed about BlueHealthConnection resources available to their BCBSM patients through articles published in the *Record*.

### Social Mission

The goal of BCBSM's social mission is to help Michigan residents be healthier, and consequently reduce health care costs. Social mission programs address health issues with serious and sometimes fatal consequences that, in many cases, are preventable. During the reporting period, BCBSM continued previous programs that targeted domestic violence, smoking, depression, physical activity and healthy weight. BCBSM recognizes the importance of these programs in addressing risk factors underlying the chronic diseases many Michigan residents face.

## Provider-Focused Use Management

Prior authorization programs ensure that sound medical criteria are met before BCBSM authorizes payment for procedures, hospitalizations and certain high-cost drugs. BCBSM has updated its precertification and prenotification programs to make them less cumbersome for providers to use and more seamless to its members. The precertification program reviews hospital admissions, while prenotification identifies potential case management referrals. Case management is a collaborative process that coordinates and evaluates options and services to meet a member's health needs through communication and available resources to promote quality, cost-effective outcomes. Radiology management controls the costs of diagnostic imaging, nuclear medicine and cardiology procedures by requiring prior authorization when these tests are performed on an outpatient basis. Utilization review conducts post-care audits to assure appropriate billing practices among providers and recovers payments that cannot be supported by medical record documentation. These programs remain effective in managing inpatient admissions, the most costly form of care.

BCBSM efforts in other programs also contribute to managing utilization. An example is BCBSM medical policy decisions about which procedures to cover. BCBSM continually reviews and evaluates new health services to determine which technologies are safe, effective and value-added. Medical necessity guidelines are established based on quality considerations and using evidence-based literature and clinical research.

## Provider-Focused Quality Management

BCBSM's quality management programs reassure groups and members that BCBSM selects and retains providers of the highest quality and collaborates with them to encourage using evidence-based care practices and safety in the health care setting such as the Cardiac Centers of

Excellence. BCBSM has performed other collaborative quality efforts that are discussed in the Quality Management Initiatives section of this report.

## Membership

During this reporting period, membership decreased by 58.7 percent or approximately 306,000 members. Even though membership declined, the ratio of patients to membership increased from 5.6 percent in 2005 to 7.5 percent in 2007 for inpatient services and 63.7 percent in 2005 to 78.1 percent in 2007 for outpatient. Reasons behind declining membership include Traditional members moving to managed care products, members losing health benefits through their employers, work force reductions, aggressive competitor pricing and a declining economy.

As shown in Charts 4A and 4B Traditional membership has declined in each age category with the greatest decrease in the age category of 50 and over. While this age group had the most significant decrease in membership, it accounted for more than 50 percent of the total payout.

The age group of 50-64 represents 40 percent of the 2007 Traditional hospital membership, while it accounted for 26 percent of the Michigan population.

**Chart 4A**
**2005 Traditional Membership by Age**

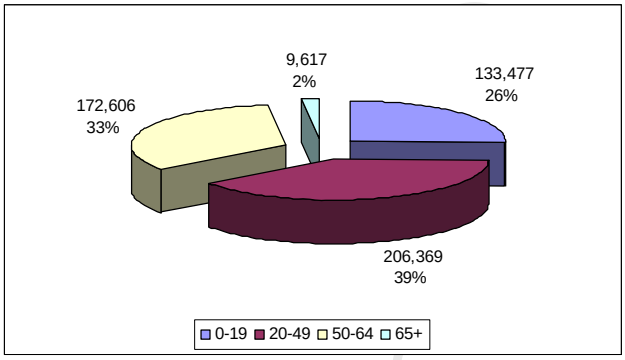
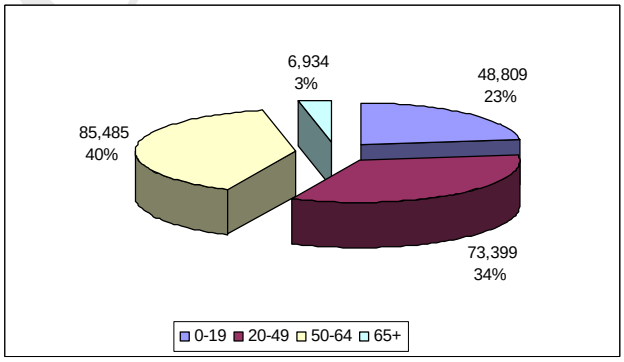



**Chart 4B**
**2007 Traditional Membership by Age**



# ACCESS GOAL PERFORMANCE

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

## PA 350 Access Objectives

### Objective 1

To ensure adequate availability of high-quality hospital services, throughout the state, at a reasonable cost to BCBSM subscribers.

## Performance - Access Goal and Objectives

Formal participation rates are derived by comparing the number of formally participating providers to the number of total licensed providers. As shown in Table 10 below, BCBSM maintained a 100 percent participation rate with hospitals in all regions of the state. The number of participating hospitals decreased from 163 in 2006 to 161 in 2007. The decrease was the result of a hospital closure and merger.

**Table 10**
**Hospital Provider Class**
**2007 - 2006 Access by Region**

| | 2007 | | | 2006 | | |
|---|---|---|---|---|---|---|
| Region | Number of Participating Providers | Total Providers | Participation Rate | Number of Participating Providers | Total Providers | Participation Rate |
| 1 | 48 | 48 | 100% | 50 | 50 | 100% |
| 2 | 9 | 9 | 100% | 9 | 9 | 100% |
| 3 | 8 | 8 | 100% | 8 | 8 | 100% |
| 4 | 6 | 6 | 100% | 6 | 6 | 100% |
| 5 | 20 | 20 | 100% | 20 | 20 | 100% |
| 6 | 22 | 22 | 100% | 22 | 22 | 100% |
| 7 | 18 | 18 | 100% | 18 | 18 | 100% |
| 8 | 14 | 14 | 100% | 14 | 14 | 100% |
| 9 | 14 | 14 | 100% | 14 | 14 | 100% |
| Ohio Hospitals | 2 | 2 | 100% | 2 | 2 | 100% |
| **Statewide** | **161** | **161** | **100%** | **163** | **163** | **100%** |

Chart 5 on page 33 provides a regional map defining the PA 350 regions and showing the 2007 distribution of participating hospitals by county. Below are main factors that helped achieve the access goal, which are highlighted in this section:

- BCBSM's reimbursement methodology
- Financial incentives for improved community standards
- Provider communication via BCBSM publications, on-line assistant tools, and provider consultants
- BCBSM hospital satisfaction studies and programs

# Provider Communications

Enhanced channels of communication helped establish and maintain a good rapport with participating providers. Satisfaction surveys have confirmed that communication is important to hospitals in doing business with BCBSM and recent survey results indicate that BCBSM was rated higher in the area of communication when compared to competitors.

## Publications and Services

BCBSM distributes to all providers a publication called *The Record*. It is a monthly source of billing, reimbursement, group-specific benefit changes, and day-to-day business information from BCBSM. *The Record* was created with input from provider focus groups as an ongoing effort to improve communications with providers and to make BCBSM information more accessible to them. In January 2007, BCBSM added "Record Select", an on-line service that allows providers to select pertinent articles by category. The articles are compiled monthly and held until BCBSM notifies the providers through e-mail when the articles are available. The articles can be reviewed online or downloaded and saved to a personal computer. More than 2,000 providers have signed up for this service and a specific article category has been created for hospitals.

Hospitals received *Hospital Update*, a bimonthly publication for hospital leadership that highlights BCBSM initiatives to solve problems and improve patient care and day-to-day business transactions. *Hospital Update* offers articles on topics such as initiatives for safer surgeries and timely news regarding the Participating Hospital Agreement and its advisory committees. Hospitals also received *Physician Update*, a monthly newsletter from BCBSM's corporate medical director. This publication provided executive summaries of important topics of interest and BCBSM programs to physicians and hospital executives.

Participating hospitals can access a comprehensive online provider manual on web-DENIS, which contains detailed instructions for servicing BCBSM members. This replaced the hard copy version of the *Guide for Participating Hospitals*. Manuals are updated as necessary allowing hospitals to obtain information on a real time basis. Topics detailed in the manual include:

- Member eligibility requirements

- Benefits and exclusions
- Criteria guidelines for services
- Documentation guidelines
- Claim submission information
- Appeals process
- Utilization review
- BCBSM departments to contact for clarification of issues

BCBSM offers providers the options of speaking with provider service representatives, writing to our inquiry department, and having a provider consultant visit provider offices to help guide and educate their staff. In addition, BCBSM trainers educated providers with seminars on various topics such as benefits and eligibility, billing, claims tracking and adjustments. BCBSM also offers providers the ability to download enrollment applications through the BCBSM.com website.

## Inquiry Systems

Web-DENIS, an electronic inquiry system, gives providers online access to health insurance information for BCBSM members via Internet connection. This system expanded from a private access network of electronic self-service features supporting provider inquires to an Internet-based program via a new secured provider portal on www.bcbsm.com. This program offers quick delivery of contract eligibility, claims status, online manuals, newsletters, fee schedules, reports and much more information needed to make doing business with BCBSM easier. BCBSM designed the Internet site to promote secure, effective, and personalized use of the Internet for existing web-DENIS users and to encourage new providers to begin to use web-DENIS.

Web-DENIS also has *Partner Links* that connect providers to BCBSM's partner sites, including the Council for Affordable Quality Healthcare, Institute for Safe Medication Practices, Michigan State Medical Society and the Michigan Health and Hospital Association.

In March 2007, web-DENIS added capability to respond to requests from providers for specific service type information regarding members of other BCBS plans. As a result, a provider can request and receive specific member benefit information, such as eligibility, benefit limitations, patient liability and coverage by place of service.

Another avenue for hospitals to obtain needed information from BCBSM is CAREN$^{+}$, an integrated voice response system which provides information on eligibility, benefits, deductibles and copayments. In 2006 CAREN$^{+}$ was enhanced to include interactive voice response technology that enables providers to enter contract numbers by voice or text. In addition, security measures were added to CAREN$^{+}$ to safeguard our members' protected health information.

In addition, results of the 2007 BCBSM Hospital Patient Account Manager Satisfaction Survey indicated satisfaction with web-DENIS remained high at 94 percent. Satisfaction with the accuracy of patient information provided by CAREN$^{+}$ and web-DENIS was also high at 86 percent. Respondents also found policy changes and BCBSM news through web-DENIS alerts was also useful.

# Reimbursement

BCBSM's reimbursement methodology was also important in maintaining participation levels. During this reporting period, BCBSM revised the Participating Hospital Agreement to include a new reimbursement methodology. Designed with input from the Michigan Hospital Association and other industry leadership, the new methodology provides fair reimbursement based on recognition of the cost of efficiently providing services to BCBSM members, as well as incentives for additional efficiency and quality initiatives.

## Peer Groups 1 through 4

Peer groups 1 through 4 include large and medium sized acute care general hospitals. For these hospitals, inpatient services are price-based using Medicare's diagnostic related groupings (DRGs) classification system. An individual hospital is reimbursed the lesser of the billed charge or the DRG specific price. Annual updates are determined based on the National Hospital Input Price Index with adjustment. The update process is described in Section IV, Exhibit B of the PHA.

BCBSM's reimbursement for outpatient laboratory, radiology, surgery, physical therapy, occupational therapy and speech therapy is price-based. The remaining outpatient services are reimbursed on an outpatient payment-to-charge ratio basis, until such time that they can be priced.

## Peer Group 5

Peer group 5 consists of small rural hospitals that are reimbursed controlled charges for both inpatient and outpatient services. The annual update for Peer Group 5 hospitals is the same as non-Peer-Group 5 hospitals. During 2007, reimbursement levels for Peer Group 5 hospitals under the PHA were modified to use the same principles approved for Peer Group 1-4 hospitals. For details see the Plan Updates section on page 4 of this report.

## Peer Groups 6 and 7

Peer groups 6 and 7 consist of psychiatric and rehabilitation hospitals and Medicare-exempt psychiatric and rehabilitation units of acute care hospitals. Reimbursement for inpatient services are on a per diem basis. Reimbursement is the lesser of the billed charge or per diem payment.

Annual updates and outpatient services reimbursement are the same as described in peer groups 1 though 4 hospitals.

## Non-Acute Services

Other hospital-based non-acute services that can be provided under another provider class plan such as, but not limited to, residential substance abuse, home health care agencies, and skilled nursing facilities will be reimbursed using a hospital-specific payment-to-charge ratio set at a level not to exceed 1.0.

BCBSM may require that these services be considered "freestanding" and that they be reimbursed under a separate agreement.

## Alternative Reimbursement Arrangements

BCBSM may consider alternative reimbursement methodologies such as "bundled" or "fixed" price arrangements covering all services per episode of care, where the reimbursement methodologies in this plan are not appropriate for payment of certain services, such as bone marrow transplants. All such alternative reimbursement methodologies will be determined through the contract administration process.

# Hospital Satisfaction Studies and Programs

BCBSM conducts annual surveys as a continued commitment to enhancing relationships with hospitals. The surveys measure overall satisfaction in doing business with BCBSM and several key elements such as service, claims processing and online tools. BCBSM uses the responses to assess what is working well and where opportunities for improvement exist. The goal of the survey process is to identify ways to make it easier for hospitals to do business with BCBSM.

During this reporting period BCBSM made changes to the annual survey process to enable hospitals and their staffs to provide more specific feedback. BCBSM modified the annual survey by alternating the target audience between hospital staff and senior hospital executives. In 2006, BCBSM's annual survey consisted of BCBSM leadership meeting face-to-face with hospital CEOs and in 2007, hospital patient account managers were surveyed by phone. Survey results are included below.

## Survey Results

Instead of mailing a survey, BCBSM leaders sat down with hospital leaders in 2006 for personal discussions about how BCBSM is doing and how it can improve. The survey results showed as much good news and positive responses as they revealed opportunities for improvement. Some of the issues earning high marks included collaboration on cost-savings and health care quality programs, claims payment and the responsiveness of the provider consulting staff. Some opportunities for improvement included the contracting and inquiry process, incentive programs and reimbursement model.

In 2007, the satisfaction survey was conducted with BCBSM hospital patient account managers, an audience that had not been surveyed since 2001. The intent of the survey was to evaluate their perceptions of how easy it was to do business with BCBSM compared to other insurers.

The survey showed that eighty-one percent of hospital account managers are more satisfied with their overall relationship and the ease of doing business with BCBSM, a nine percent increase compared to 2001 results. In addition, more than two-thirds of the respondents would recommend BCBSM to their colleagues and when compared to other insurers, 71 percent of survey respondents consider BCBSM to be better overall. The helpfulness of provider consultants and high satisfaction of on-line tools contributed to the positive results. Opportunities for improvement were cited for decreasing phone wait times, increasing training and support, and providing more accurate and consistent responses.

## Provider Affiliation Strategy Programs

BCBSM's provider affiliation strategy is a fundamental approach to doing business that fosters an ongoing commitment to excellent performance and dialogue with providers. To better serve our communities and customers, BCBSM promotes business relationships with providers so they will:

- Collaborate with BCBSM to improve the health status of patients and the quality and cost effectiveness of care
- Help BCBSM deliver outstanding customer service to members
- Value BCBSM as a health plan of choice and recommend it to patients and others

The Provider Affiliation Strategy focuses on the following key elements that support a strong relationship with providers:

- Prompt and accurate claims payment
- Consistent, accurate and responsive service
- Timely and effective communication
- Partnerships to promote and facilitate better health care

### Prompt, Accurate Claims Payment

BCBSM initiated programs to improve the quality and timeliness of system changes to improve the percentage of claims reimbursed on the first submission. At the same time, BCBSM also initiated a process to reduce the number of initial claim rejections.

BCBSM's adjustment rate initiative was designed to reduce the number of claims that are manually adjusted to process through BCBSM's claim system. During 2006, claim rejections were reduced by 30 percent in select claim categories. The reduction is the result of clarification of billing and reimbursement guidelines, removal of unnecessary edits and standardization of medical policy rejections. Some of the projects included minimizing the need for additional information requests, aligning billing and reimbursement policies related to emergency services and eliminating billing requirements regarding newborns and mothers being billed on a single UB claim form.

In response to requests from providers, BCBSM streamlined the hospital precertification process in 2007 to create an easier and more efficient process. Precertification is a process that requires the review of patients' symptoms and proposed treatment, to determine in advance whether they

meet BCBSM's criteria for inpatient treatment. BCBSM placed greater reliance on providers to manage patient lengths of stay. This change diminished the administrative burden of obtaining frequent recertification without significantly increasing lengths of stay.

## Responsive Service

BCBSM's Provider Consulting Services increased provider satisfaction by building relationships through enhanced visibility, communication and consultative services. Provider consultants advocate for the priority and resolution of issues identified by providers to assure their needs are communicated to and acted upon by BCBSM. Consultants assisted providers with complex billing issues, answered their benefit questions and educated their staffs on billing policies and procedures. Consultants also provided written materials that may help providers' staffs in their daily work.

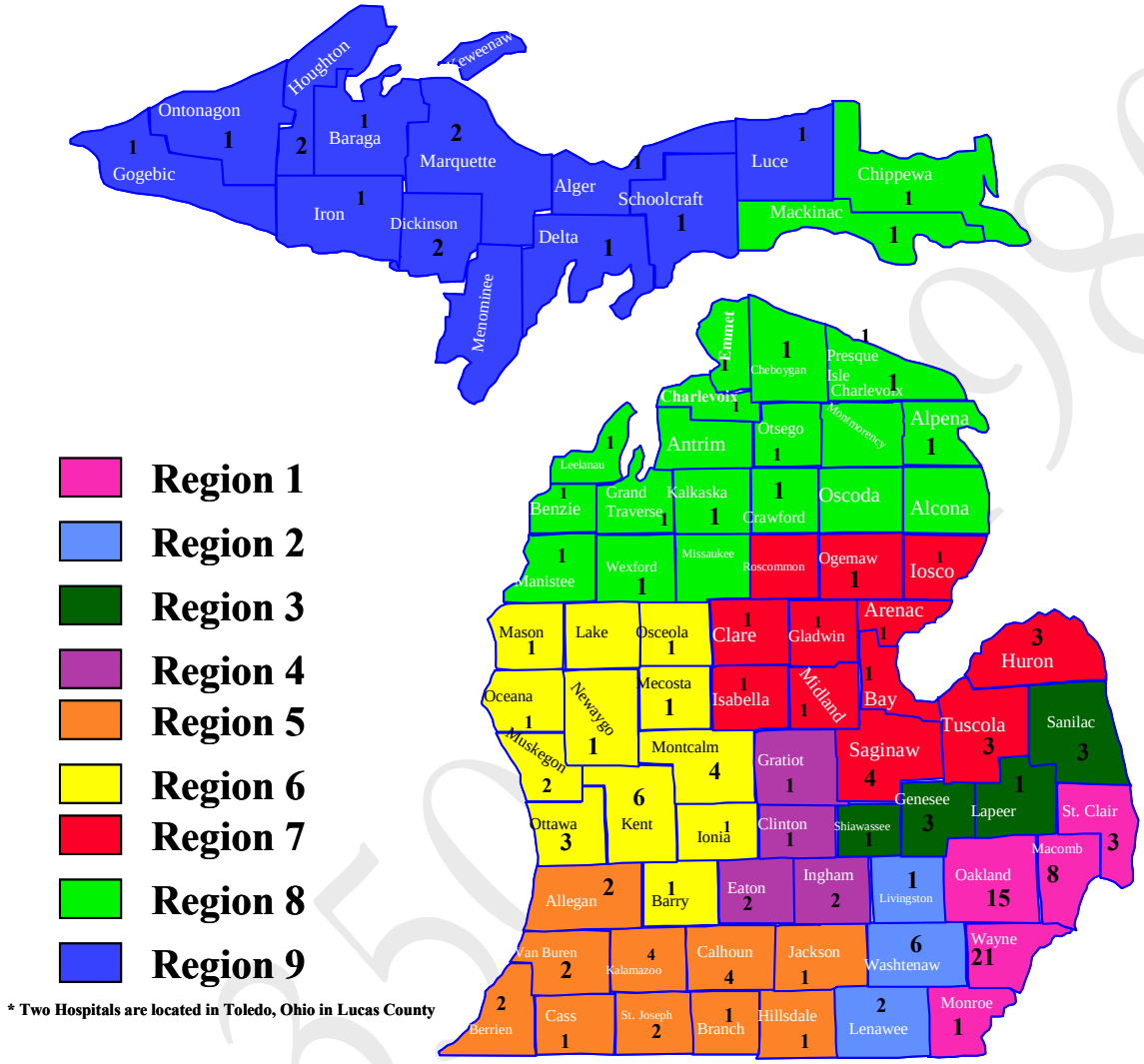
During 2007, BCBSM added more professional fee schedules on web-DENIS to help providers conduct business more efficiently with BCBSM. In addition, improvements were made to answer provider calls faster, which reduced wait time to less than sixty seconds.

## Effective Communications

BCBSM increased face-to-face feedback opportunities through provider outreach fairs. The fairs were held throughout the state, giving providers the opportunity to interact with BCBSM representatives and to discuss web-DENIS, provider training, electronic data interchange and other topics. Total attendance at the outreach fairs in 2006 and 2007 was approximately 2,000 each year. Many of the outreach fairs were held in hospitals located throughout the state. No specific information is available on how many hospital representatives were in attendance.

During 2007, the provider section of the BCBSM Web site was redesigned for easier navigation. New features were added, such as online registration for seminars and national provider identifier reporting. In addition, self-paced on-line training modules with interactive animation and learning exercises, designed to guide providers on how to use electronic provider manuals, benefit detail records, maximum fee schedules and other resources, were added.

## Hospital Provider Class
## Chart 5




*** Two Hospitals are located in Toledo, Ohio in Lucas County**

# QUALITY OF CARE GOAL PEFORMANCE

"Providers will meet and abide by reasonable standards of health care quality."

## PA 350 Quality of Care Objectives

### Objective 1

To ensure the provision of quality care to BCBSM subscribers through the application of participation qualifications and performance standards as a basis for hospital participation.

## Performance on Quality of Care Goal and Objectives

BCBSM's approach to achieving the quality of care objective for the hospital provider class was to:

- Ensure the quality of care by enforcing qualification standards for participation
- Maintain quality controls through utilization management and audits
- Implement quality management initiatives that promote safety, improve the health of the community and ensure the delivery of high quality health care
- Develop strong relationships with participating providers by offering them various avenues to receive information and to voice concerns

## Qualification Standards

BCBSM offers all short-term general acute care hospitals, short-term psychiatric care hospitals, and intensive rehabilitation programs the opportunity to participate providing they meet BCBSM's qualification standards. Hospitals must be licensed by the state of Michigan, comply with federal government standards (e.g., Medicare certification), have appropriate accreditation and comply with the Certificate of Need requirements of the Michigan Public Health Code. The specifics of these requirements and additional qualification standards are listed in the Hospital Provider Class Plan and Exhibit A of the PHA.

# Quality and Use Management Tools

## Utilization Management

BCBSM uses an admission precertification process to manage inpatient utilization and provide interventions that ensure members receive appropriate, high quality and cost-effective care.

### Prenotification and Precertification of Admissions

Prenotification is an electronic process that allows participating hospitals to notify BCBSM of inpatient admissions using web-DENIS. Timely prenotification allows BCBSM to quickly identify cases for potential intervention by BlueHealthConnection programs and helps ensure that claims will be paid appropriately.

Precertification of admissions ensures that the inpatient setting is medically appropriate for the patient's condition and level of care. Precertification is a telephonic process and is only required of hospitals when admissions do not meet InterQual criteria or the admission is not eligible for prenotification. Admissions for psychiatric care, substance abuse treatment, rehabilitation therapy, skilled nursing care and certain admissions to Peer Group 5 hospitals are not eligible for prenotification and must be precertified.

## Audits

During utilization review audits paid claims data and the corresponding medical records are reviewed to ensure that admissions to the hospitals and outpatient services were appropriate and the services rendered were performed for the appropriate indications, in appropriate settings and that services were accurately billed and paid. Providers are selected for audit based on a number of factors, including:

- Random selection
- Prior audit history
- Referrals from internal or external sources
- Last audit occurred over a year ago

At the conclusion of an audit, a departure conference with the facility representative provides preliminary findings identified during the audit. The departure conference also serves as an opportunity for education. Methods to enhance correct coding and billing practices are discussed and facilities are encouraged to build on existing strengths. As a result, performance can and should immediately improve.

Within six weeks, the facility receives a letter detailing the final results of the audit. This letter identifies individual problem cases (e.g., diagnosis errors, billing errors, inappropriate settings, coding errors and incorrect DRG selection), problem patterns, and any refunds due BCBSM. The letter also specifies related corrective actions. Finally, the letter describes the appeals process available to providers who disagree with BCBSM audit findings. BCBSM conducts a variety of audits that review hospital performance for medical appropriateness, appropriateness of setting and compliance with benefits and billing requirements. Routine auditing functions include the following types of audits:

## Medical Necessity Review

Reviews for medical necessity verify that the care and treatment are appropriate for the symptoms and consistent with the diagnosis. BCBSM verifies that the type, level and length of care and the setting are necessary to provide safe and appropriate care based on InterQual criteria for inpatient care.

## DRG Validation Reviews

DRG validation audits were conducted for hospitals in Peer Groups 1 through 4 to verify the accuracy of ICD-9-CM codes, diagnoses and procedures from medical records and the DRG assigned by BCBSM. All hospitals in Peer Groups 1-4 are reviewed each year.

## Readmission Case Reviews

Readmission audits identify admissions that occur within 14 days of a previous discharge that should be combined resulting in a single DRG payment because the patient was either:

- discharged prematurely necessitating an unplanned hospital readmission
- the subsequent admission was planned without a medical reason for the delay in services, or
- the readmission is for continued care and services rendered during the previous admission

## Catastrophic Case Reviews

Catastrophic cases are subject to review and recovery of over payments. A case is defined as catastrophic if its calculated cost exceeds the DRG payment by at least $30,000. Payment for catastrophic cases is 75 percent of the excess cost. The cost is determined by applying the hospital-specific cost-to-charge ratio to covered charges. Catastrophic case reviews are performed on peer group 1 through 4 hospitals, which are reimbursed for inpatient admissions based on DRGs.

## Focus Reviews

Focus reviews involve a review of problematic diagnoses or services. Hospitals are selected for review through quarterly analyses of the pre-notification and pre-certification paid-claims file. Cases are reviewed for the appropriateness of admission and each day of care. Hospitals are also reviewed for compliance with pre-notification and focused pre-certification requirements.

## Hospital Outpatient Audits

Hospital outpatient audits are conducted to verify that services billed are covered, ordered by a physician and have a documented result, billed correctly with appropriate procedure codes, diagnosis codes and revenue codes and to determine whether services were medically appropriate. Services reviewed include, but are not limited to observation beds, cardiac rehabilitation, laboratory, radiology, physical therapy, occupational therapy, speech and language pathology services, high-dollar services, emergency room services and outpatient surgery. The review focuses on verifying that services billed and paid are benefits under the member's contract and that the services billed match the services that were ordered and performed.

### Financial Investigations

Our Corporate and Financial Investigations department follows up on reports of improper activity by patients and providers and, if improper activity is substantiated, refers information for possible legal action. CFI reviews information from a number of different sources to determine when an investigation is necessary.

## Provider Appeals Process

In accordance with sections 402(1), 403 and 404 of PA 350, BCBSM makes a formal appeals process available to hospitals. A description of the process can be found in Exhibit D of the PHA. The appeals process is available to providers that disagree with BCBSM determinations as the result of audit findings. Hospitals are informed of the appeals process through *The Record*, the online provider manual, and the PHA. Hospitals are again made aware of the appeals process during utilization review audits.

Details of audit activity for the reporting period are provided in Appendix E of this report:

# Quality Management Initiatives

BCBSM continues its commitment to "best in class" quality management through several innovative programs geared to improve the quality of care.

## Hospital Pay for Performance Program

BCBSM implemented the Hospital Pay for Performance program in 2006 as part of the revised Participating Hospital Agreement. This program rewards hospitals for performance on quality and efficiency measures. The program was developed via a collaborative effort with the Michigan Health and Hospital Association, hospitals, physicians, pharmacists, and other quality experts. The Pay for Performance program (P4P) replaced the earlier Hospital Incentive Program and offers expanded quality improvement measures, efficiency measures and the opportunity for hospitals to earn a higher incentive rate.[18]

The 2006 P4P program gave top performing hospitals in peer groups 1-4 the opportunity to earn up to an additional three percent on their inpatient and outpatient operating payments if they met specific performance thresholds. This amount was a significant increase from the prior reward level, which was capped at 4 percent of *inpatient* payments only. The potential reward amount increased again in 2007 to 4 percent of inpatient and outpatient operating payments. Hospitals were also given the opportunity to earn up to an additional 1 percent based on a comparison of Michigan hospital cost to other states in the region.

A P4P program for peer group 5 hospitals was implemented in 2007 and will be phased in over several years. The peer group 5 pay for performance program will not affect hospital payments until 2009.

[18] BCBSM Hospital Update, Aug.-Sept. 2007.

The goals of the P4P program are to:

- Promote consistent delivery of clinically sound health care services (best practices)
- Provide incentives to encourage continuous quality improvement
- Promote patient safety, including medication safety and other safe hospital practices
- Reduce health care costs through quality of care improvements
- Encourage participation in multi-institutional, hospital-based collaborative quality initiatives

Table 11 shows the weights assigned to each component of the P4P program to calculate provider performance payments for hospitals in peer groups 1-4 in years 2006 and 2007.

**Table 11**
**Pay for Performance Program Components and Weights**
**2006-2007**

| Program Component | 2006 Weight | 2007 Weight |
|---|---|---|
| Pre-Qualifying Conditions | 0% | 0% |
| Quality | 60% | 45% - 55% |
| Community Health Initiatives* | 10% | NA |
| Collaborative Quality Initiatives | 30% | 10% - 20% |
| Efficiency | NA | 35% |

* In 2006, 10 percent of the P4P incentive applied to community health initiatives related to smoking cessation, physical activity and nutrition.

## Prequalifying Conditions

In 2007, hospitals were required to meet the following three pre-qualifying conditions to participate in the P4P program:

1. Publicly report performance on all applicable quality indicators to the Centers for Medicare & Medicaid Services. This condition is applicable to the entire program. If a hospital fails to meet this condition, it forfeits its eligibility for the entire Pay for Performance program.

2. Maintain participation in all selected collaborative initiatives for which it is eligible. If a hospital fails to meet this condition it will forfeit its eligibility for payment under the Collaborative Quality Initiatives component, but it will not be precluded from earning payment for the quality or efficiency components of the program. CQIs are outlined later in the report.

3. Implement and maintain a culture of safety, medication safety and patient safety practices and patient safety technology. This component, which includes specific criteria for maintaining a culture of safety, was scored as a separate measure prior to 2007. It was changed into a pre-qualifying condition in 2007.

## Quality Initiatives

Hospitals were evaluated on the following six quality indicators in the 2007 Pay for Performance program:

- Heart failure
- Pneumonia
- Surgical infection prevention
- Acute myocardial infarction "perfect care"
- Central line associated blood stream infection rates
- ICU ventilator bundle

The AMI "perfect care" indicator was scored at the patient level for the first time in 2007. This methodology, which is also called an "all or none" measurement, requires a hospital to meet the requirement for all applicable measures for each patient. If one or more of the measures was not met, and the measure was not contraindicated, the hospital did not receive credit for that patient.

The indicator for ICU central line associated blood stream infection rates was new in 2007. This measure compares the performance of Michigan hospitals to a national indicator. It is measured on a statewide basis, with all hospitals receiving the same score.

## Efficiency Initiatives

Beginning in 2006, hospital efficiency was measured by hospitals' standardized inpatient cost per case relative to the statewide mean. Hospitals were rewarded based on their performance relative to the statewide mean.

## Collaborative Quality Initiatives

Inclusion of Collaborative Quality Initiatives in the P4P program began in 2006. Hospitals were evaluated on their participation in the following six Collaborative Quality Initiatives (CQIs).

- Blue Cross Blue Shield of Michigan Cardiac Consortium Angioplasty Project
- Michigan Society of Cardiovascular and Thoracic Surgeons Quality Improvement Initiative
- Michigan Bariatric Surgery Collaborative
- Michigan Surgery Quality Collaborative
- Michigan Breast Oncology Initiative
- MHA Keystone project on hospital associated infections

For each initiative, BCBSM sponsors an academic leader to develop and coordinate clinical registries on these specific procedures or conditions. BCBSM is funding a substantial portion of the data collection costs, the project coordination and coordination of quality improvement efforts. Although BCBSM provides financial support, the data and results belong to the participant hospitals. The goal of these initiatives is to evaluate and improve the quality of care while ultimately reducing health care delivery costs.

Appendix F provides a brief description of each of the CQIs included in the Hospital Pay for Performance program.

### Regional Benchmark Cost Comparison

Hospitals have the potential to earn up to an additional 1 percent of their combined inpatient and outpatient operating payments based on a comparison of the statewide average cost-per-adjusted admission with a regional benchmark. This comparison is not a hospital-specific measure. Instead, it is applied equally to all eligible hospitals participating in the Hospital Pay for Performance program.

The inclusion of the regional benchmark comparison in the P4P program gives hospitals the opportunity to earn a maximum of 5 percent in incentives on their BCBSM inpatient and outpatient payments. This component of the program was available for the first time in 2007.

### Success of the Hospital Pay for Performance Program

Hospital performance has continued to improve under the Pay for Performance Programs. Statewide performance on program measures in 2005 was 72 percent. In 2006, statewide performance rose to 78 percent. Performance in 2007 remained at 78 percent although some program components and scoring requirements were modified between 2005 and 2007. Incentive payments to hospitals totaled approximately $75 million in 2006 and $100 million in 2007.

The ninety Michigan hospitals that participated in the program in 2006 achieved near perfect scores on two measures for treating patients suffering from heart attacks. These hospitals performed at a higher rate than comparable Michigan hospitals that didn't participate in the program and they also outscored the national average of hospitals around the country. Because of the strong results, BCBSM and participating hospitals implement the "perfect care," measurement to evaluate quality of care for treating patients with acute myocardial infarctions in 2007.

## Other Quality Initiatives

### BCBSM Advanced Cardiovascular Imaging Consortium

Launched in 2007, this initiative studies the use of coronary computed tomography angiography, a promising, noninvasive technology that could replace conventional cardiac catheterization in the future. CCTA uses contrast materials in the arteries and high-resolution CT machinery to obtain detailed images of blood vessels and the heart.

William Beaumont Hospital is coordinating the program with data provided by participating providers in the Advanced Cardiovascular Imaging Consortium. The ACIC is a group of providers charged with developing and monitoring the best uses, techniques and interpretation of CCTA.

Consortium providers collect and report data to a central database to document the use of CCTA, develop best practice guidelines for providers and start a continuous quality improvement program in cardiovascular imaging. Each participating consortium group will be able to compare its data with aggregate performance data from all groups in the study.

## Cardiac Centers of Excellence

BCBSM established the Cardiac Centers of Excellence Program in 1996 to assist members in making informed choices about their cardiac care, as well as to enhance long-term relationships between BCBSM and providers to improve quality in cardiac care through research and collaboration. Research has demonstrated that where people receive cardiac services matters in terms of outcomes. Hospitals that perform a high volume of these services and carefully monitor their performance achieve the best results for cardiac patients. The procedures covered in the program are:

- Coronary artery bypass graft
- Percutaneous transluminal coronary angioplasty
- Cardiac value repair or replacement
- Cardiac or coronary artery catheterization

The CCOE program identifies hospitals committed to continuous internal and external reviews of their cardiac care, with a common goal of improving the quality of care — which ultimately leads to positive outcomes and cost savings. While members are encouraged to use hospitals in the Centers of Excellence Program, they will not incur additional out-of-pocket costs if they choose another network hospital for cardiac services.

The hospital selection process includes a comprehensive review of staff credentials, cardiac procedure volumes, frequency of medical complications and deaths associated with cardiac procedures, and the hospital's methods for monitoring and evaluating care, including continuous quality improvement efforts. Hospitals are subject to periodic re-evaluations as criteria change with advancements in medicine.

Hospitals must reapply every two years to maintain their status as a cardiac center of excellence. In 2006 thirteen Michigan hospitals were designated as cardiac centers of excellence by BCBSM. In 2005, ten hospitals had achieved this designation.

## The Michigan Quality Improvement Consortium

The Michigan Quality Improvement Consortium is a collaborative effort by physicians and others from Michigan health maintenance organizations, the Michigan State Medical Society, the Michigan Osteopathic Association, the Michigan Association of Health Plans, the Michigan Peer Review Organization and Blue Cross Blue Shield of Michigan.

The consortium uses a collaborative approach to develop and implement guidelines for the treatment of common conditions as well as performance measures to show how often the guidelines are being used. The guidelines support the delivery of consistent, evidence-based health care services that will improve health outcomes for Michigan patients.

The consortium has developed evidence-based practice guidelines for the treatment of diabetes, asthma, depression, heart failure and tobacco control. MQIC published 10 additional guidelines in 2006-2007 on the following clinical topics:

- Routine prenatal and postnatal care
- Pediatric obesity
- Chronic kidney disease
- Pediatric preventive services
- Low back pain
- Attention deficit hyperactivity disorder
- Chronic obstructive pulmonary disease
- Medical management post myocardial infarction
- Acute bronchitis
- Upper respiratory infection in pediatrics

MQIC guidelines are based on scientific evidence as reported in the most current national guidelines and feedback from MQIC-participating health plans, providers, the Michigan Department of Community Health and medical specialty societies.

## Michigan Health & Safety Coalition

Blue Cross Blue Shield of Michigan provides leadership and significant funding and staff support to the MH&SC, an independent non-profit organization. The MH&SC is chaired by BCBSM and includes a number of key stakeholders committed to improving patient safety in all health care settings.

The coalition was named the State Commission on Patient Safety by Governor Jennifer Granholm. Three regional public hearings were held to receive testimony on patient safety concerns from health care stakeholders including physicians, hospitals, nurses, pharmacists and other health care professionals, health care organizations, professional associations, purchasers, health plans and consumers. A report containing thirteen broad recommendations on how to improve patient safety in Michigan was presented to the Governor in November 2005 and released to the public in March 2006.

The MH&SC actively promotes hospital participation in The Leapfrog Group's annual survey of safety and quality and is a licensee of Leapfrog's data set which is used for safety analysis and improvement. As of December 31, 2007, 58% of eligible Michigan hospitals, urban and rural, participated in the Leapfrog survey.

Results from the first year of the hospital survey indicated opportunity for improvement in ICU care. The MH&SC convened a collaborative to develop a hospital toolkit for implementing the ICU hospital guideline. This toolkit was shared in hardcopy and electronically with hospitals and ICU physicians and nurses.

The MH&SC sponsors an annual educational conference on patient safety, which draws over 200 clinical and management professionals working in all settings of health care. The 2007 program addressed safety in hospital and outpatient settings.

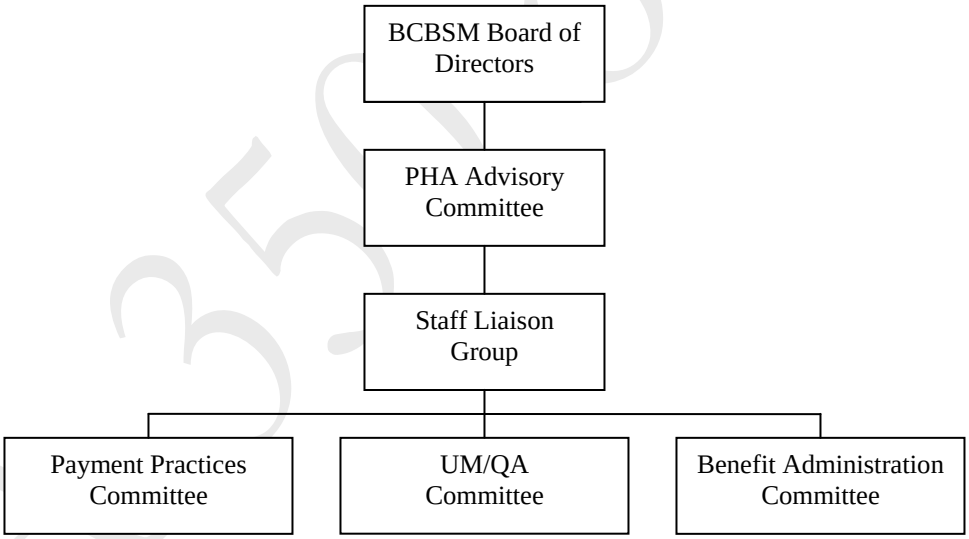
# Provider Relations

During this review period, BCBSM maintained effective relations with hospitals through the contract administration process and a formal appeals process.

## Contract Administration Process

The Participating Hospital Agreement provides for an ongoing contract administration process (CAP) through which participating hospitals can provide non-binding input and recommendations to BCBSM. The CAP is organized through several committees comprised of BCBSM staff or appointees, Michigan Health and Hospital Association staff or appointees, and representatives from participating hospitals. The organization of the contract administration process is as follows:

**Chart 6**
**Contract Administration Committee Structure**




The role of each PHA committee is described below. All PHA committees meet throughout the year as necessary. A list of topics discussed by each committee during the reporting period is included in Appendix G.

### PHA Advisory Committee

This committee is made up of members appointed by BCBSM and the Michigan Health and Hospital Association. The group is charged with providing input and making non-binding recommendations to the BCBSM board of directors regarding the administration of and any modifications to the Participating Hospital Agreement.

## Staff Liaison Group

The Staff Liaison Group is comprised of the co-chairpersons of the Benefit Administration Committee, Utilization Management and Quality Assessment Committee and Payment Practices Committee. The Staff Liaison Group meets as necessary to oversee and coordinate the activities of these three committees and to develop recommendations and reports to the PHA Advisory Committee.

## Utilization Management and Quality Assessment Committee

This committee includes BCBSM senior and mid-level management, Michigan Health and Hospital Association staff and representatives from the participating hospitals. The committee provides input on matters related to utilization, quality and health management activities.

## Benefit Administration Committee.

The Benefit Administration Committee handles matters related to problems administering the PHA. The Committee consists of BCBSM and MHA administrative staff and personnel from participating hospitals.

# CONCLUSION

## Cost Goal

During the 2006-2007 reporting period, the two-year average percent change in hospital payments per 1000 increased 21.8 percent. The PA 350 cost goal was to limit the increase to 4.6 percent. The change was due to an average increase in use of 22.7 percent for inpatient admissions and 18.8 percent for outpatient visits. There were a number of factors that influenced hospital payments, including:

- Utilization of benefits by existing members grew considerably in the hospital environment. This scenario resulted in fewer members to absorb the cost of increased admissions and outpatient visits.
- The hospital industry continues to transition from performing surgical procedures in the inpatient setting to the outpatient environment. However, during the current period, inpatient utilization per 1000 members had the more significant growth.
- The majority of hospital payments were for members in the age category 55 years and older, a population for which the demand for hospital care and health resources will rise as they continue to age.

## Access Goal

BCBSM met the access goal for the hospital provider class. BCBSM offered licensed providers the opportunity to participate by signing a formal participation agreement. One hundred percent participation was achieved in both years of the reporting period. On a regional level, there were a sufficient number of hospitals located in each region. This level of access ensures acute care coverage and fewer out-of-pocket expenses for members. Effective provider communications, BCBSM's revised reimbursement methodology, financial incentives for quality and safety community programs and provider satisfaction studies all helped achieve the access goal.

## Quality of Care Goal

BCBSM achieved the quality of care goal. Hospitals were required to meet qualification standards to ensure they were capable of providing high quality care to BCBSM members. Quality controls, which included utilization review initiatives and audits, ensured that services rendered were medically necessary, appropriate for the patient's condition and in accordance with the PHA. Quality management initiatives such as the PHA Pay for Performance Program, BCBSM Cardiovascular Consortium, Cardiac Centers of Excellence, Michigan Quality Improvement Consortium and the Michigan Health and Safety Coalition promoted patient safety and the delivery of high quality care.

The PHA contract administration process gave providers a formal process to address concerns and provide input and recommendations on issues related to doing business with BCBSM.

# APPENDIX A

## Overview of Public Act 350

This section briefly describes the provider class plan annual reporting requirements mandated under Public Act 350.

### Annual reporting requirements

The provider class plan annual reports are submitted pursuant to section 517 of PA 350, which requires BCBSM to submit to the Commissioner an annual report for each provider class that shows the level of BCBSM's achievement of the goals provided in section 504.

### PA 350 Goals

The term "goals", used in section 517 above, refers to specific cost, access and quality goals described in section 504. This section states:

"A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of health care services in accordance with the following goals:

### Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." This is expressed by the following formula:

$$\left[ \frac{((100 + I) \times (100 + REG))}{100} \right] - 100$$

### Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

### Quality of Health Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

# Calculation of 2006 – 2007 Cost Goal

## P.A. 350 Cost Goal Formula

The P.A. 350 cost goal formula , as stated in the Act is:

$$\frac{((100 + I) \times (100 + REG)}{100} \quad -100$$

## Goal Calculations (see attached sheet for yearly indicators)

| Year of Determination | 2008 |
|---|---|
| I (CY 2007 - 2006) | 2.654% (matches the CPI closely) |
| REG (CY 2007 - 2004) | 1.925% |

Applying these indices into the formula, the cost goal becomes:

$$\frac{((100 + I\%) \times (100 + REG\%)}{100} \quad -100 = \mathbf{4.579\%}$$

PA 350 Cost Goal Assumptions

| Year | Population (1) | Real GNP (2) | Per Capita GNP | Implicit GNP Price Deflator (3) | Percent Change PC GNP | Percent Change IPD |
|---|---|---|---|---|---|---|
| **2003** | 290,116,000 | $ 10,540,500,000,000 | $ 36,332.02 | 107.18 | | |
| **2004** | 292,801,000 | $ 10,844,400,000,000 | $ 37,036.76 | 110.67 | **1.940%** | **3.252%** |
| **2005** | 295,507,000 | $ 11,151,100,000,000 | $ 37,735.49 | 114.38 | **1.887%** | **3.360%** |
| **2006** | 298,217,000 | $ 11,447,800,000,000 | $ 38,387.48 | 117.51 | **1.728%** | **2.734%** |
| **2007** | 300,913,000 | $ 11,799,100,000,000 | $ 39,211.00 | 120.54 | **2.145%** | **2.573%** |

(1) Population projections based on 2000 census released May 11, 2004
www.census.gov/ipc/www/usinterimproj/usproj detail file RTT (Total Resident Population)

(2) http://research.stlouisfed.org/fred2/series/GNPC96/downloaddata?cid=106

(3) http://research.stlouisfed.org/fred2/series/GNPDEF/downloaddata?cid=21

## Definitions

Section 504 of the Act also provides the following definitions for terms used in the cost goal calculation:

"'Gross Domestic Product (GDP) in constant dollars' means that term as defined and annually published by the United States Department of Commerce, Bureau of Economic Analysis."

"'Implicit price deflator for gross national product' means that term as defined and annually published by the United States Department of Commerce, Bureau of Economic Analysis."

"'Inflation' (I) means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made."

"'Compound rate of inflation and real economic growth' means the ratio of the quantity 100 plus inflation multiplied by the quantity 100 plus real economic growth to 100; minus 100."

"'Rate of change in the total corporation payment per member to each provider class' means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the Commissioner's determination."

"'Real economic growth' (REG) means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made."

## Determination Process

Under PA 350, the commissioner is required to consider information presented in the annual report, as well as all other relevant factors that might affect the performance of a particular provider class, in making a determination with respect to that class.

Section 509 of the Act outlines factors that should be considered by the commissioner to "determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan." Many of these factors are beyond BCBSM's direct control and may adversely impact the cost and use of health care services for a particular provider class. Specifically, section 509(4) states:

*The commissioner shall consider all of the following in making a determination...:*

*(a) Annual reports transmitted pursuant to section 517.*

*(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. The commissioner shall give weight to each of the goals provided in section 504, shall not focus on one goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.*

*(c) Information submitted or obtained for the record concerning:*

- *Demographic trends;*
- *Epidemiological trends;*
- *Long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d);*
- *Sudden changes in circumstances;*
- *Administrative agency or judicial actions;*
- *Changes in health care practices and technology; and,*
- *Changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.*

*(d) Health care legislation of this state or of the federal government. As used in this subdivision, 'health care legislation' does not include Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.*

*(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, and comments received pursuant to section 505(2).*

*After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in sections 504, and the objectives contained in the provider class plan, the commissioner shall determine one of the following [as stated under section 510(1)]:*

*(a) That the provider class plan achieves the goals of the corporation as provided in section 504.*

*(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to factors listed in section 509(4).*

*(c) That a provider class plan does not substantially achieve one or more of the goals of the corporation as provided in section 504.*

*A determination made by the commissioner under section 510 1(a) or 1(b) would require no further action by the corporation. Upon a 511(1)(c) determination by the commissioner, under section 511, the corporation:*

*(1) Within 6 months or a period determined by the commissioner..., shall transmit to the commissioner a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2). In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.*

*If after 6 months or a period determined by the commissioner..., the health care corporation has failed to act pursuant to subsection (1), the commissioner shall prepare a provider class plan..., for that provider* class.

The findings of the commissioner may be disputed by any party through an appeals process available under section 515 of PA 350.

# APPENDIX B

## Technical Notes

The data indices presented in the 2005, 2006, and 2007 databases and analyzed in the annual reports reflect a defined subset of BCBSM claims experience. The data specifications and collection methodologies are discussed in the following sections.

### Data Elements and Collection

The basic statistics analyzed for each provider class are total payments and utilization, from which an average price per utilization unit is derived. These data were collected from BCBSM data files that are based on claims submitted to the Corporation and approved for payment to the provider or in some cases, the subscriber.

The data collection period captures health care services incurred during specific twelve-month calendar years and paid through fourteen months. For example, the 2007 dataset includes all services incurred between 1/1/07 and 12/31/07, and paid from 1/1/07 through 2/28/08. It is reasonable to expect that for the hospital provider class, approximately 97 percent of total experience is captured.

Participation rates are based on providers who sign a BCBSM participation agreement and the total number of licensed providers registered with BCBSM.

### Scope of the Data

#### *Provider Class Accountability*

PA 350 requires BCBSM to report its Traditional line of business for the purposes of provider class accountability. However, for the ancillary provider classes, including pharmacy, managed care experience is included. BCBSM membership systems capture members' product line information only once, reflecting the member's hospital/medical-surgical coverage (e.g., a member with managed care pharmacy coverage but traditional hospital/medical-surgical coverage is considered a traditional member).

Underwritten groups and administrative services contracts are included. For ancillary provider classes, complementary claims and membership data is included. The data excludes the Federal Employee Program and non-Michigan liability such as claims paid through the Inter-Plan Teleprocessing System for out-of-state Blue members. Claims incurred out-of-state by BCBSM members are also excluded.

Blue Care Network data are excluded from the reporting requirements referred to in PA 350 Section 502(a) (11) and the HMO Act.

#### *Regional Experience*

Regions selected for analysis are compatible with Michigan Metropolitan Statistical Areas (MSAs) and provide an acceptable basis for analysis of access as well as of provider practice patterns.

The data cover total Traditional business, divided into nine regions. Regions one through nine represent groups of Michigan counties. Michigan claims experience with unidentified zip codes was allocated among the nine regions according to the distribution of data with identifiable zip codes.

## *Membership*

This report includes all BCBSM Traditional members residing in Michigan.

The regions used for analysis pertain to the location where services were delivered. For example, region one experience represents payments to region one providers for services rendered to BCBSM members regardless of residency. This is because subscribers who live in one region may receive services in another region because they reside near a border or want services from a provider in another region.

# APPENDIX C

## Supporting Tables and Charts

| Table # found in body | Appendix # | Description |
|---|---|---|
| **Table 5** | **C1** | 2006-2007 Cost, Use and Price Experience by MDC Inpatient |
| | **C2** | 2005 Cost, Use and Price Experience by MDC Inpatient |
| **Table 6** | **C3** | 2005-2007 Cost, Use and Price by DRG Inpatient |
| **Table 8** | **C4** | 2006-2007 Cost, Use and Price Experience by MDC Outpatient |
| | **C5** | 2005 Cost, Use and Price Experience by MDC Outpatient |
| **Table 9** | **C6** | 2007 Cost, Use and Price Experience by Top 50 Diagnoses Outpatient |
| | **C7** | 2006 Cost, Use and Price Experience by Top 50 Diagnoses Outpatient |
| | **C8** | 2005 Cost, Use and Price Experience by Top 50 Diagnoses Outpatient |
| **N/A** | **C9** | 2007 Cost, Use and Price Experience by Top 50 Diagnoses Inpatient |
| | **C10** | 2006 Cost, Use and Price Experience by Top 50 Diagnoses Inpatient |
| | **C11** | 2005 Cost, Use and Price Experience by Top 50 Diagnoses Inpatient |
| | **C12** | 2007 Outpatient Traditional Payments by Age |

# Appendix – C1

## Hospital Provider Class – Inpatient
## 2007 Cost, Use, and Price Experience by MDC

| Inpatient Hospital by Major Diagnostic Catergory | Two year average rate of change Per 1000 Members | | | | 2007 Payments | 2007 Days/Svcs | 2007 Adm | 2007 Avg Pmt/Day | 2007 Avg Pmt/Adm | Pct to Total Payout |
|---|---|---|---|---|---|---|---|---|---|---|
| | Payments | Days | Adm | Pmt/Adm | | | | | | |
| Nervous System | 39.5% | 29.0% | 19.4% | 16.8% | $ 12,908,303 | 4,054 | 826 | $ 3,184 | $ 15,627 | 5.9% |
| Disease of the Eye | -3.8% | 14.0% | 23.3% | -22.0% | $ 78,639 | 44 | 17 | $ 1,787 | $ 4,626 | 0.0% |
| Disease of ENT | 1.0% | 5.8% | 14.4% | -11.7% | $ 1,570,624 | 604 | 224 | $ 2,600 | $ 7,012 | 0.7% |
| Respiratory System | 30.3% | 20.0% | 16.9% | 11.5% | $ 17,753,552 | 7,643 | 1,565 | $ 2,323 | $ 11,344 | 8.2% |
| Circulatory System | 19.3% | 15.4% | 7.5% | 10.9% | $ 39,059,664 | 8,767 | 2,242 | $ 4,455 | $ 17,422 | 17.9% |
| Digestive System | 34.5% | 19.6% | 13.7% | 18.3% | $ 20,510,147 | 9,041 | 1,876 | $ 2,269 | $ 10,933 | 9.4% |
| Hepatobiliary Sys/Pancreas | 36.2% | 7.9% | 25.3% | 8.6% | $ 6,588,775 | 2,685 | 546 | $ 2,454 | $ 12,067 | 3.0% |
| Musculorskeletal | 30.9% | 15.0% | 17.1% | 11.8% | $ 40,893,912 | 9,655 | 2,729 | $ 4,236 | $ 14,985 | 18.8% |
| Skin & Subcutaneous Disease | 24.5% | 13.2% | 11.7% | 11.5% | $ 3,251,681 | 1,766 | 468 | $ 1,841 | $ 6,948 | 1.5% |
| Nutritional Disease | 26.6% | 23.4% | 19.2% | 6.2% | $ 9,065,176 | 2,792 | 835 | $ 3,247 | $ 10,856 | 4.2% |
| Kidney/Urinary Tract | 20.1% | 5.7% | 15.4% | 4.1% | $ 6,016,954 | 2,224 | 607 | $ 2,705 | $ 9,913 | 2.8% |
| Male Reproductive Sys | 47.0% | 28.1% | 15.9% | 26.8% | $ 2,025,908 | 406 | 187 | $ 4,990 | $ 10,834 | 0.9% |
| Female Reproductive Sys | 26.4% | 12.3% | 9.8% | 15.1% | $ 7,700,763 | 2,281 | 953 | $ 3,376 | $ 8,081 | 3.5% |
| Pregnancy | -23.6% | -1.4% | -1.9% | -22.1% | $ 7,923,568 | 5,747 | 2,201 | $ 1,379 | $ 3,600 | 3.6% |
| Newborns in Perinatal Period | 44.8% | 128.7% | 768.8% | -83.3% | $ 6,197,763 | 5,004 | 2,048 | $ 1,239 | $ 3,026 | 2.8% |
| Disease of the Blood | 19.8% | 19.3% | 15.6% | 3.7% | $ 2,096,613 | 1,018 | 227 | $ 2,060 | $ 9,236 | 1.0% |
| Neoplasms | 41.4% | 25.2% | 11.9% | 26.4% | $ 5,825,491 | 1,905 | 189 | $ 3,058 | $ 30,823 | 2.7% |
| Infectious Disease | 67.9% | 34.9% | 40.2% | 19.8% | $ 6,059,288 | 2,680 | 372 | $ 2,261 | $ 16,288 | 2.8% |
| Mental Disorders | 24.2% | 20.9% | 17.7% | 5.5% | $ 6,532,142 | 7,283 | 1,217 | $ 897 | $ 5,367 | 3.0% |
| Alcohol/Drug Abuse | 38.7% | 33.0% | 41.2% | -1.8% | $ 299,277 | 296 | 73 | $ 1,011 | $ 4,100 | 0.1% |
| Injury Poisoning | 54.0% | 36.2% | 35.3% | 13.8% | $ 5,645,893 | 2,556 | 523 | $ 2,209 | $ 10,795 | 2.6% |
| Burns | 41.8% | 97.8% | -0.3% | 42.2% | $ 333,633 | 75 | 11 | $ 4,448 | $ 30,330 | 0.2% |
| Factors Influencing Health Status | 41.1% | 28.8% | 21.5% | 16.1% | $ 8,808,765 | 5,114 | 706 | $ 1,722 | $ 12,477 | 4.0% |
| Human Immunodeficiency Virus Infections | 323.6% | 344.9% | 286.9% | 9.5% | $ 140,617 | 92 | 8 | $ 1,528 | $ 17,577 | 0.1% |
| Other | 533.0% | 530.2% | 306.2% | 55.8% | $ 347,022 | 139 | 42 | $ 2,497 | $ 8,262 | 0.2% |
| **Total** | **27.5%** | **21.6%** | **24.6%** | **2.3%** | **$ 217,634,171** | **83,871** | **20,692** | **$ 2,595** | **$ 10,518** | **100%** |

## Hospital Provider Class – Inpatient
## 2006 Cost, Use, and Price Experience by MDC

| Inpatient Hospital by Major Diagnostic Catergory | Two year average rate of change Per 1000 Members | | | | 2006 Payments | 2006 Days/Svcs | 2006 Adm | 2006 Avg Pmt/Day | 2006 Avg Pmt/Adm | Pct to Total Payout |
|---|---|---|---|---|---|---|---|---|---|---|
| | Payments | Days | Adm | Pmt/Adm | | | | | | |
| Nervous System | 29.0% | 11.0% | 10.7% | 16.6% | $ 13,429,081 | 4,558 | 1,004 | $ 2,946 | $ 13,376 | 5.4% |
| Disease of the Eye | -36.6% | -51.5% | -28.9% | -10.8% | $ 118,553 | 56 | 20 | $ 2,117 | $ 5,928 | 0.0% |
| Disease of ENT | 32.2% | 9.5% | 3.6% | 27.6% | $ 2,256,217 | 828 | 284 | $ 2,725 | $ 7,944 | 0.9% |
| Respiratory System | 15.1% | 5.4% | -0.1% | 15.3% | $ 19,760,138 | 9,243 | 1,943 | $ 2,138 | $ 10,170 | 8.0% |
| Circulatory System | 9.2% | 1.3% | 6.6% | 2.5% | $ 47,517,622 | 11,020 | 3,025 | $ 4,312 | $ 15,708 | 19.2% |
| Digestive System | 24.5% | 15.7% | 16.8% | 6.6% | $ 22,122,602 | 10,965 | 2,393 | $ 2,018 | $ 9,245 | 8.9% |
| Hepatobiliary Sys/Pancreas | 20.0% | 27.7% | 13.3% | 5.9% | $ 7,019,707 | 3,611 | 632 | $ 1,944 | $ 11,107 | 2.8% |
| Musculorskeletal | 23.5% | 19.4% | 15.2% | 7.2% | $ 45,336,444 | 12,183 | 3,382 | $ 3,721 | $ 13,405 | 18.3% |
| Skin & Subcutaneous Disease | 19.6% | 16.1% | 14.3% | 4.7% | $ 3,788,373 | 2,264 | 608 | $ 1,673 | $ 6,231 | 1.5% |
| Nutritional Disease | 21.9% | 8.9% | 9.9% | 11.0% | $ 10,391,083 | 3,283 | 1,016 | $ 3,165 | $ 10,227 | 4.2% |
| Kidney/Urinary Tract | 28.6% | 25.1% | 14.0% | 12.8% | $ 7,267,532 | 3,054 | 763 | $ 2,380 | $ 9,525 | 2.9% |
| Male Reproductive Sys | 15.0% | -7.0% | 9.2% | 5.3% | $ 1,999,135 | 460 | 234 | $ 4,346 | $ 8,543 | 0.8% |
| Female Reproductive Sys | 3.0% | -4.3% | -1.7% | 4.7% | $ 8,836,185 | 2,947 | 1,259 | $ 2,998 | $ 7,018 | 3.6% |
| Pregnancy | 12.7% | 9.7% | 6.0% | 6.3% | $ 15,042,393 | 8,454 | 3,256 | $ 1,779 | $ 4,620 | 6.1% |
| Newborns in Perinatal Period | 16.9% | -5.0% | 4.7% | 11.7% | $ 6,208,443 | 3,175 | 342 | $ 1,955 | $ 18,153 | 2.5% |
| Disease of the Blood | 37.4% | 21.8% | 23.0% | 11.7% | $ 2,539,112 | 1,238 | 285 | $ 2,051 | $ 8,909 | 1.0% |
| Neoplasms | 3.6% | -2.0% | 3.4% | 0.2% | $ 5,975,855 | 2,208 | 245 | $ 2,706 | $ 24,391 | 2.4% |
| Infectious Disease | 30.2% | 17.4% | 12.5% | 15.8% | $ 5,236,485 | 2,883 | 385 | $ 1,816 | $ 13,601 | 2.1% |
| Mental Disorders | 38.2% | 24.3% | 27.2% | 8.6% | $ 7,628,301 | 8,741 | 1,500 | $ 873 | $ 5,086 | 3.1% |
| Alcohol/Drug Abuse | 65.4% | 35.6% | 33.3% | 24.1% | $ 313,105 | 323 | 75 | $ 969 | $ 4,175 | 0.1% |
| Injury Poisoning | 15.8% | 12.3% | 10.5% | 4.8% | $ 5,320,129 | 2,723 | 561 | $ 1,954 | $ 9,483 | 2.1% |
| Burns | 108.1% | -33.9% | 6.9% | 94.6% | $ 341,325 | 55 | 16 | $ 6,206 | $ 21,333 | 0.1% |
| Factors Influencing Health Status | 11.6% | 8.6% | 3.0% | 8.4% | $ 9,059,752 | 5,759 | 843 | $ 1,573 | $ 10,747 | 3.7% |
| Human Immunodeficiency Virus Infections | -62.9% | -60.8% | -66.6% | 11.0% | $ 48,163 | 30 | 3 | $ 1,605 | $ 16,054 | 0.0% |
| Other | 210.6% | 167.3% | 213.3% | -0.9% | $ 79,534 | 32 | 15 | $ 2,485 | $ 5,302 | 0.0% |
| **Total** | **17.9%** | **11.1%** | **9.7%** | **7.5%** | **$ 247,635,267** | **100,093** | **24,089** | **$ 2,474** | **$ 10,280** | **100%** |

**Appendix – C2**

Hospital Provider Class – Inpatient

2005 Cost, Use, and Price Experience by MDC

| Inpatient Hospital by Major Diagnostic Catergory | 2005 Payments | 2005 Days | 2005 Adm | 2005 Avg Pmt/Day | 2005 Avg Pmt/Adm | Pct to Total Payout |
|---|---|---|---|---|---|---|
| Nervous System | $ 17,391,182 | 6,863 | 1,516 | $ 2,534 | $ 11,472 | 5.0% |
| Disease of the Eye | $ 312,382 | 193 | 47 | $ 1,619 | $ 6,646 | 0.1% |
| Disease of ENT | $ 2,851,448 | 1,263 | 458 | $ 2,258 | $ 6,226 | 0.8% |
| Respiratory System | $ 28,677,844 | 14,658 | 3,251 | $ 1,956 | $ 8,821 | 8.2% |
| Circulatory System | $ 72,700,698 | 18,172 | 4,742 | $ 4,001 | $ 15,331 | 20.7% |
| Digestive System | $ 29,700,917 | 15,835 | 3,424 | $ 1,876 | $ 8,674 | 8.5% |
| Hepatobiliary Sys/Pancreas | $ 9,776,300 | 4,723 | 932 | $ 2,070 | $ 10,490 | 2.8% |
| Musculorskeletal | $ 61,342,846 | 17,044 | 4,905 | $ 3,599 | $ 12,506 | 17.5% |
| Skin & Subcutaneous Disease | $ 5,291,960 | 3,258 | 889 | $ 1,624 | $ 5,953 | 1.5% |
| Nutritional Disease | $ 14,241,881 | 5,039 | 1,545 | $ 2,826 | $ 9,218 | 4.1% |
| Kidney/Urinary Tract | $ 9,443,297 | 4,078 | 1,118 | $ 2,316 | $ 8,447 | 2.7% |
| Male Reproductive Sys | $ 2,904,150 | 826 | 358 | $ 3,516 | $ 8,112 | 0.8% |
| Female Reproductive Sys | $ 14,340,604 | 5,143 | 2,139 | $ 2,788 | $ 6,704 | 4.1% |
| Pregnancy | $ 22,303,609 | 12,880 | 5,130 | $ 1,732 | $ 4,348 | 6.4% |
| Newborns in Perinatal Period | $ 8,875,965 | 5,586 | 546 | $ 1,589 | $ 16,256 | 2.5% |
| Disease of the Blood | $ 3,087,647 | 1,698 | 387 | $ 1,818 | $ 7,978 | 0.9% |
| Neoplasms | $ 9,638,161 | 3,766 | 396 | $ 2,559 | $ 24,339 | 2.7% |
| Infectious Disease | $ 6,717,415 | 4,103 | 572 | $ 1,637 | $ 11,744 | 1.9% |
| Mental Disorders | $ 9,223,739 | 11,747 | 1,970 | $ 785 | $ 4,682 | 2.6% |
| Alcohol/Drug Abuse | $ 316,334 | 398 | 94 | $ 795 | $ 3,365 | 0.1% |
| Injury Poisoning | $ 7,674,232 | 4,050 | 848 | $ 1,895 | $ 9,050 | 2.2% |
| Burns | $ 274,028 | 139 | 25 | $ 1,971 | $ 10,961 | 0.1% |
| Factors Influencing Health Status | $ 13,564,790 | 8,863 | 1,368 | $ 1,530 | $ 9,916 | 3.9% |
| Human Immunodeficiency Virus Infections | $ 216,878 | 128 | 15 | $ 1,694 | $ 14,459 | 0.1% |
| Other | $ 42,787 | 20 | 8 | $ 2,139 | $ 5,348 | 0.0% |
| **Total** | **$ 350,911,094** | **150,473** | **36,683** | **$ 2,332** | **$ 9,566** | **100%** |

# Appendix – C3

## Hospital Provider Class – Inpatient
## 2007 Cost, Use, and Price Experience by Top 50 Diagnostic Related Groups

| Diagnositc Related Group | Two year average rate of change Per 1000 Members | | | | 2007 Payments | 2007 Days | 2007 Adm | 2007 Avg Pmt/Day | 2007 Avg Pmt/Case | Pct to Total Payout |
|---|---|---|---|---|---|---|---|---|---|---|
| | Payments | Days | Admissions | Pmt/Adm | | | | | | |
| Major Joint Replacement | 46.9% | 27.5% | 30.7% | 12.4% | $ 14,746,407 | 2,550 | 791 | $ 5,783 | $ 18,643 | 6.8% |
| Ecmo Or Trach W Mv 96+Hrs W Maj O.R. | 5.4% | -6.9% | 0.2% | 5.3% | $ 4,638,510 | 1,027 | 29 | $ 4,517 | $159,949 | 2.1% |
| Percutaneous Cardiovascular W Drug-Eluting Stent | -17.5% | -27.5% | -23.7% | 8.1% | $ 3,832,892 | 342 | 261 | $ 11,207 | $ 14,685 | 1.8% |
| O.R. Procedures For Obesity | 9.9% | 0.2% | 1.3% | 8.5% | $ 3,254,106 | 484 | 227 | $ 6,723 | $ 14,335 | 1.5% |
| Uterine & Adnexa Proc For Non-Malignancy W/O Cc | 10.4% | -4.9% | 0.0% | 10.4% | $ 3,208,552 | 900 | 457 | $ 3,565 | $ 7,021 | 1.5% |
| Rehabilitation | 9.2% | 3.5% | 9.3% | -0.1% | $ 2,823,582 | 2,194 | 180 | $ 1,287 | $ 15,687 | 1.3% |
| Cesarean Section W/O Cc | -17.4% | -7.2% | -0.8% | -16.7% | $ 2,542,637 | 1,468 | 484 | $ 1,732 | $ 5,253 | 1.2% |
| Trach W Mv 96+Hrs W/O Maj O.R. | 106.3% | 42.1% | 93.4% | 6.6% | $ 2,512,639 | 530 | 24 | $ 4,741 | $104,693 | 1.2% |
| Percutaneous Cardiovascular W Drug-Eluting Stent | -19.0% | -7.5% | -24.3% | 7.0% | $ 2,435,312 | 383 | 120 | $ 6,359 | $ 20,294 | 1.1% |
| Vaginal Delivery W/O Complicating Diagnoses | -36.3% | 8.5% | 2.8% | -38.0% | $ 2,270,861 | 2,186 | 1,081 | $ 1,039 | $ 2,101 | 1.0% |
| **Top 10** | **22.6%** | **18.7%** | **26.5%** | **-3.1%** | **$ 96,247,448** | **30,161** | **8,484** | **$ 3,191** | **$ 11,345** | **44.2%** |
| Top 50 | 10.1% | 4.9% | 3.4% | 6.4% | $ 42,265,498 | 12,064 | 3,654 | $ 3,503 | $ 11,567 | 19.4% |
| **Grand Total** | **27.5%** | **21.6%** | **24.6%** | **2.3%** | **$ 217,634,171** | **83,871** | **20,692** | **$ 2,595** | **$ 10,518** | **100.0%** |

## Hospital Provider Class – Inpatient
## 2006 Cost, Use, and Price Experience by Top 50 Diagnostics Related Groups

| Diagnositc Related Group | Two year average rate of change Per 1000 Members | | | | 2006 Payments | 2006 Days | 2006 Adm | 2006 Avg Pmt/Day | 2006 Avg Pmt/Case | Pct to Total Payout |
|---|---|---|---|---|---|---|---|---|---|---|
| | Payments | Days | Admissions | Pmt/Adm | | | | | | |
| Major Joint Replacement | 445.2% | 438.0% | 423.9% | 4.1% | $ 14,562,383 | 2,901 | 878 | $ 5,020 | $ 16,586 | 5.9% |
| Percutaneous Cardiovascular W Drug-Eluting Stent | 432.9% | 407.9% | 441.7% | -1.6% | $ 6,739,777 | 684 | 496 | $ 9,853 | $ 13,588 | 2.7% |
| Ecmo Or Trach W Mv 96+Hrs W Maj O.R. | 113.7% | 78.0% | 106.4% | 3.5% | $ 6,382,124 | 1,600 | 42 | $ 3,989 | $151,955 | 2.6% |
| Vaginal Delivery W/O Complicating Diagnoses | 3.0% | 1.1% | 0.7% | 2.2% | $ 5,171,095 | 2,923 | 1,526 | $ 1,769 | $ 3,389 | 2.1% |
| Cesarean Section W/O Cc | 17.4% | 18.2% | 12.4% | 4.4% | $ 4,466,375 | 2,294 | 708 | $ 1,947 | $ 6,308 | 1.8% |
| Percutaneous Cardiovascular W Drug-Eluting Stent | 463.8% | 437.0% | 441.3% | 4.2% | $ 4,363,221 | 601 | 230 | $ 7,260 | $ 18,971 | 1.8% |
| O.R. Procedures For Obesity | 14.5% | -8.1% | 13.8% | 0.6% | $ 4,294,001 | 701 | 325 | $ 6,126 | $ 13,212 | 1.7% |
| Uterine & Adnexa Proc For Non-Malignancy W/O Cc | 5.5% | -4.1% | -0.2% | 5.7% | $ 4,215,854 | 1,373 | 663 | $ 3,071 | $ 6,359 | 1.7% |
| Rehabilitation | 12.0% | 8.4% | -3.3% | 15.9% | $ 3,752,887 | 3,074 | 239 | $ 1,221 | $ 15,702 | 1.5% |
| Cardiac Valve W/O Card Cath | 16.7% | 37.1% | 24.3% | -6.1% | $ 2,292,066 | 485 | 64 | $ 4,726 | $ 35,814 | 0.9% |
| **Top 10** | **50.9%** | **21.1%** | **26.7%** | **19.1%** | **$ 113,880,271** | **36,855** | **9,727** | **$ 3,090** | **$ 11,708** | **46.0%** |
| Top 50 | 84.0% | 34.1% | 38.7% | 32.6% | $ 55,715,147 | 16,692 | 5,125 | $ 3,338 | $ 10,871 | 22.5% |
| **Grand Total** | **17.9%** | **11.1%** | **9.7%** | **7.5%** | **$ 247,635,267** | **100,093** | **24,089** | **$ 2,474** | **$ 10,280** | **100.0%** |

## Hospital Provider Class – Inpatient
## 2005 Cost, Use, and Price Experience by Top 50 Diagnostics Related Groups

| Diagnositc Related Group | Payments | 2005 Days | 2005 Adm | 2005 Avg Pmt/Day | 2005 Avg Pmt/Case | Pct to Total Payout |
|---|---|---|---|---|---|---|
| Vaginal Delivery W/O Complicating Diagnoses | $ 8,391,659 | 4,831 | 2,531 | $ 1,737 | $ 3,316 | 2.4% |
| Uterine & Adnexa Proc For Non-Malignancy W/O Cc | $ 6,679,632 | 2,392 | 1,110 | $ 2,792 | $ 6,018 | 1.9% |
| Cesarean Section W/O Cc | $ 6,357,948 | 3,243 | 1,052 | $ 1,961 | $ 6,044 | 1.8% |
| O.R. Procedures For Obesity | $ 6,265,213 | 1,274 | 477 | $ 4,918 | $ 13,135 | 1.8% |
| Rehabilitation | $ 5,597,362 | 4,737 | 413 | $ 1,182 | $ 13,553 | 1.6% |
| Ecmo Or Trach W Mv 96+Hrs W Maj O.R. | $ 4,990,285 | 1,502 | 34 | $ 3,322 | $146,773 | 1.4% |
| Major Joint Replacement | $ 4,462,424 | 901 | 280 | $ 4,953 | $ 15,937 | 1.3% |
| Trach W Mv 96+Hrs W/O Maj O.R. | $ 4,448,969 | 1,502 | 52 | $ 2,962 | $ 85,557 | 1.3% |
| Extreme Immaturity Or Respiratory Distress Syndrome, Neonate | $ 4,138,512 | 2,274 | 71 | $ 1,820 | $ 58,289 | 1.2% |
| Spinal Fusion Except Cervical W Cc | $ 3,417,620 | 869 | 163 | $ 3,933 | $ 20,967 | 1.0% |
| **Top 10** | **$ 126,067,671** | **50,837** | **12,825** | **$ 2,480** | **$ 9,830** | **35.9%** |
| Top 50 | $ 50,599,577 | 20,794 | 6,173 | $ 2,433 | $ 8,197 | 14.4% |
| **Grand Total** | **$ 350,911,094** | **150,473** | **36,683** | **$ 2,332** | **$ 9,566** | **100.0%** |

# Appendix – C4

## Hospital Provider Class – Outpatient
## 2007 Cost, Use, and Price Experience by MDC

| Outpatient Hospital by Major Diagnostic Category | Two year average rate of change Per 1000 Members | | | 2007 | 2007 | Avg | Pct of Total | |
|---|---|---|---|---|---|---|---|---|
| | Payments | Visits | Pmt/Vst | Payments | Visits | Pmt/Vst | Payout | Visits |
| Nervous System | 20.8% | 15.5% | 4.6% | $ 8,031,803 | 35,337 | $ 227 | 3.7% | 2.6% |
| Disease of the Eye | 26.9% | 10.4% | 14.9% | $ 4,130,388 | 13,341 | $ 310 | 1.9% | 1.0% |
| Disease of ENT | 14.9% | 7.8% | 6.6% | $ 9,158,683 | 61,999 | $ 148 | 4.2% | 4.5% |
| Respiratory System | 13.7% | 12.9% | 0.7% | $ 15,877,379 | 95,240 | $ 167 | 7.4% | 7.0% |
| Circulatory System | 14.4% | 15.9% | -1.3% | $ 16,456,073 | 87,158 | $ 189 | 7.6% | 6.4% |
| Digestive System | 15.2% | 10.2% | 4.5% | $ 24,115,753 | 159,912 | $ 151 | 11.2% | 11.7% |
| Hepatobiliary Sys/Pancreas | 22.9% | 15.9% | 6.1% | $ 4,917,734 | 29,026 | $ 169 | 2.3% | 2.1% |
| Musculorskeletal | 14.4% | 11.1% | 3.0% | $ 39,940,910 | 192,018 | $ 208 | 18.5% | 14.1% |
| Skin & Subcutaneous Disease | 23.2% | 13.8% | 8.2% | $ 16,848,337 | 85,540 | $ 197 | 7.8% | 6.3% |
| Nutritional Disease | 25.5% | 14.3% | 9.8% | $ 9,199,275 | 127,110 | $ 72 | 4.3% | 9.3% |
| Kidney/Urinary Tract | 21.6% | 14.6% | 6.1% | $ 11,340,403 | 91,350 | $ 124 | 5.3% | 6.7% |
| Male Reproductive Sys | 51.5% | 16.8% | 29.7% | $ 3,838,405 | 15,248 | $ 252 | 1.8% | 1.1% |
| Female Reproductive Sys | 15.3% | 9.1% | 5.6% | $ 8,296,812 | 47,216 | $ 176 | 3.8% | 3.5% |
| Pregnancy | -3.0% | 2.1% | -5.0% | $ 1,621,166 | 13,422 | $ 121 | 0.8% | 1.0% |
| Newborns in Perinatal Period | 12.0% | 11.6% | 0.3% | $ 127,558 | 921 | $ 138 | 0.1% | 0.1% |
| Disease of the Blood | 33.6% | 9.5% | 22.0% | $ 4,516,922 | 46,863 | $ 96 | 2.1% | 3.4% |
| Neoplasms | 17.9% | 19.2% | -1.1% | $ 7,727,140 | 35,444 | $ 218 | 3.6% | 2.6% |
| Infectious Disease | 6.6% | 5.8% | 0.8% | $ 858,163 | 10,474 | $ 82 | 0.4% | 0.8% |
| Mental Disorders | 25.7% | 13.9% | 10.4% | $ 976,551 | 8,192 | $ 119 | 0.5% | 0.6% |
| Alcohol/Drug Abuse | 11.5% | -1.0% | 12.7% | $ 296,366 | 2,414 | $ 123 | 0.1% | 0.2% |
| Injury Poisoning | 22.4% | 12.7% | 8.6% | $ 1,778,631 | 9,127 | $ 195 | 0.8% | 0.7% |
| Burns | 9.0% | 8.8% | 0.2% | $ 93,456 | 464 | $ 201 | 0.0% | 0.0% |
| Factors Influencing Health Status | 23.5% | 15.3% | 7.1% | $ 23,617,847 | 191,220 | $ 124 | 11.0% | 14.0% |
| Human Immunodeficiency Virus | 91.7% | 35.4% | 41.6% | $ 122,731 | 809 | $ 152 | 0.1% | 0.1% |
| Other | 56.2% | 6.5% | 46.7% | $ 192,423 | 672 | $ 286 | 0.1% | 0.0% |
| Unknown | 66.2% | 91.9% | -13.4% | $ 1,563,110 | 4,032 | $ 388 | 0.7% | 0.3% |
| **Total** | **18.8%** | **13.1%** | **5.0%** | **$ 215,644,018** | **1,364,549** | **$ 158** | **100.0%** | **100.0%** |

## Hospital Provider Class – Outpatient
## 2006 Cost, Use, and Price Experience by MDC

| Outpatient Hospital by Major Diagnostic Category | Two year average rate of change Per 1000 Members | | | 2006 | 2006 | Avg | Pct of Total | |
|---|---|---|---|---|---|---|---|---|
| | Payments | Visits | Pmt/Vst | Payments | Visits | Pmt/Vst | Payout | Visits |
| Nervous System | 17.2% | 7.5% | 8.9% | $ 9,644,088 | 12,647 | $ 763 | 3.7% | 1.8% |
| Disease of the Eye | 15.8% | 9.6% | 5.7% | $ 4,723,744 | 6,198 | $ 762 | 1.8% | 0.9% |
| Disease of ENT | 13.4% | 3.9% | 9.1% | $ 11,566,631 | 31,832 | $ 363 | 4.4% | 4.7% |
| Respiratory System | 16.5% | 6.0% | 9.9% | $ 20,267,467 | 34,267 | $ 591 | 7.7% | 5.0% |
| Circulatory System | 25.3% | 16.0% | 8.0% | $ 20,860,953 | 47,658 | $ 438 | 7.9% | 7.0% |
| Digestive System | 19.8% | 13.7% | 5.4% | $ 30,366,338 | 50,178 | $ 605 | 11.5% | 7.3% |
| Hepatobiliary Sys/Pancreas | 19.8% | 12.8% | 6.3% | $ 5,803,676 | 7,000 | $ 829 | 2.2% | 1.0% |
| Musculorskeletal | 20.6% | 11.6% | 8.1% | $ 50,642,895 | 94,707 | $ 535 | 19.2% | 13.8% |
| Skin & Subcutaneous Disease | 33.4% | 12.7% | 18.3% | $ 19,847,702 | 46,802 | $ 424 | 7.5% | 6.8% |
| Nutritional Disease | 21.5% | 13.7% | 6.9% | $ 10,636,780 | 87,598 | $ 121 | 4.0% | 12.8% |
| Kidney/Urinary Tract | 19.3% | 12.9% | 5.7% | $ 13,531,400 | 34,192 | $ 396 | 5.1% | 5.0% |
| Male Reproductive Sys | 17.7% | 12.3% | 4.8% | $ 3,675,713 | 7,164 | $ 513 | 1.4% | 1.0% |
| Female Reproductive Sys | 23.4% | 8.3% | 13.9% | $ 10,443,927 | 23,157 | $ 451 | 4.0% | 3.4% |
| Pregnancy | 10.2% | 2.7% | 7.3% | $ 2,425,044 | 8,858 | $ 274 | 0.9% | 1.3% |
| Newborns in Perinatal Period | 135.3% | 4.0% | 126.2% | $ 165,240 | 933 | $ 177 | 0.1% | 0.1% |
| Disease of the Blood | 48.1% | 15.3% | 28.4% | $ 4,905,939 | 21,670 | $ 226 | 1.9% | 3.2% |
| Neoplasms | 30.8% | 15.9% | 12.8% | $ 9,508,852 | 12,379 | $ 768 | 3.6% | 1.8% |
| Infectious Disease | 14.3% | 2.6% | 11.4% | $ 1,167,872 | 8,074 | $ 145 | 0.4% | 1.2% |
| Mental Disorders | 36.3% | 17.2% | 16.3% | $ 1,127,294 | 5,350 | $ 211 | 0.4% | 0.8% |
| Alcohol/Drug Abuse | 86.1% | 37.7% | 35.1% | $ 385,524 | 1,129 | $ 341 | 0.1% | 0.2% |
| Injury Poisoning | 22.4% | 7.7% | 13.6% | $ 2,108,574 | 5,414 | $ 389 | 0.8% | 0.8% |
| Burns | 8.7% | 8.1% | 0.5% | $ 124,393 | 473 | $ 263 | 0.0% | 0.1% |
| Factors Influencing Health Status | 28.2% | 13.9% | 12.6% | $ 27,755,441 | 134,119 | $ 207 | 10.5% | 19.6% |
| Human Immunodeficiency Virus | 57.9% | 24.3% | 27.0% | $ 92,862 | 419 | $ 222 | 0.0% | 0.1% |
| Other | -4.7% | 5.0% | -9.2% | $ 178,745 | 455 | $ 393 | 0.1% | 0.1% |
| Unknown | 1115.0% | 585.4% | 77.3% | $ 1,364,576 | 1,289 | $ 1,059 | 0.5% | 0.2% |
| **Total** | **23.0%** | **12.2%** | **9.7%** | **$ 263,321,669** | **683,962** | **$ 385** | **100.0%** | **100.0%** |

**Appendix – C5**

Hospital Provider Class – Outpatient

2005 Cost, Use, and Price Experience by MDC

| Outpatient Hospital by Major Diagnostic Category | 2005 Payments | 2005 Visits | Avg Pmt/Vst | Pct of Total Payout | Pct of Total Visits |
|---|---|---|---|---|---|
| Nervous System | $ 13,753,859 | 19,534 | $ 704 | 3.8% | 1.9% |
| Disease of the Eye | $ 6,813,101 | 9,449 | $ 721 | 1.9% | 0.9% |
| Disease of ENT | $ 17,041,588 | 51,148 | $ 333 | 4.8% | 5.0% |
| Respiratory System | $ 29,068,334 | 54,033 | $ 538 | 8.1% | 5.3% |
| Circulatory System | $ 27,807,039 | 68,545 | $ 406 | 7.8% | 6.7% |
| Digestive System | $ 42,354,522 | 73,800 | $ 574 | 11.8% | 7.2% |
| Hepatobiliary Sys/Pancreas | $ 8,092,191 | 10,372 | $ 780 | 2.3% | 1.0% |
| Musculorskeletal | $ 70,137,045 | 141,569 | $ 495 | 19.6% | 13.9% |
| Skin & Subcutaneous Disease | $ 24,866,479 | 69,381 | $ 358 | 7.0% | 6.8% |
| Nutritional Disease | $ 14,625,512 | 128,694 | $ 114 | 4.1% | 12.6% |
| Kidney/Urinary Tract | $ 18,950,173 | 50,604 | $ 374 | 5.3% | 5.0% |
| Male Reproductive Sys | $ 5,216,454 | 10,665 | $ 489 | 1.5% | 1.0% |
| Female Reproductive Sys | $ 14,141,691 | 35,719 | $ 396 | 4.0% | 3.5% |
| Pregnancy | $ 3,676,077 | 14,407 | $ 255 | 1.0% | 1.4% |
| Newborns in Perinatal Period | $ 117,348 | 1,497 | $ 78 | 0.0% | 0.1% |
| Disease of the Blood | $ 5,535,805 | 31,347 | $ 177 | 1.5% | 3.1% |
| Neoplasms | $ 12,148,680 | 17,863 | $ 680 | 3.4% | 1.8% |
| Infectious Disease | $ 1,707,368 | 13,155 | $ 130 | 0.5% | 1.3% |
| Mental Disorders | $ 1,381,767 | 7,560 | $ 183 | 0.4% | 0.7% |
| Alcohol/Drug Abuse | $ 346,053 | 1,370 | $ 253 | 0.1% | 0.1% |
| Injury Poisoning | $ 2,877,920 | 8,404 | $ 342 | 0.8% | 0.8% |
| Burns | $ 191,265 | 723 | $ 265 | 0.1% | 0.1% |
| Factors Influencing Health Status | $ 36,163,941 | 196,684 | $ 184 | 10.1% | 19.3% |
| Human Immunodeficiency Virus Infections | $ 98,258 | 563 | $ 175 | 0.0% | 0.1% |
| Other | $ 313,398 | 724 | $ 433 | 0.1% | 0.1% |
| Unknown | $ 187,655 | 314 | $ 598 | 0.1% | 0.0% |
| **Total** | **$ 357,613,525** | **1,018,124** | **$ 351** | **100.0%** | **100.0%** |

# Appendix – C6

Hospital Provider Class – Outpatient

2007 Cost, Use, and Price Experience by Top 50 Diagnoses

| Outpatient Hospital by Top 50 Diagnoses | Two year average rate of change Per 1000 Members | | | 2007 Payments | 2007 Visits | Avg Pmt/Vst | % of Total Payout |
|---|---|---|---|---|---|---|---|
| | Payments | Visits | Pmt/Vst | | | | |
| Malign Neopl Breast Nos | 20.2% | 16.3% | 3.3% | $ 4,797,577 | 4,895 | $ 980 | 6.4% |
| Chest Pain Nos | 5.0% | 7.6% | -2.4% | $ 4,026,627 | 4,450 | $ 905 | 5.4% |
| Antineoplastic Chemo Enc | 24.2% | 39.9% | -11.2% | $ 3,995,268 | 1,312 | $ 3,045 | 5.3% |
| Chest Pain Nec | 8.0% | 6.6% | 1.3% | $ 3,122,323 | 1,919 | $ 1,627 | 4.1% |
| Crnry Athrscl Natve Vssl | 28.6% | 8.5% | 18.5% | $ 3,040,522 | 1,644 | $ 1,849 | 4.0% |
| Screen Mammogram Nec | 34.2% | 15.3% | 16.3% | $ 2,835,361 | 24,262 | $ 117 | 3.8% |
| Malign Neopl Prostate | 55.8% | 12.8% | 38.1% | $ 2,774,450 | 2,364 | $ 1,174 | 3.7% |
| Lumbago | 12.4% | 4.5% | 7.6% | $ 2,254,886 | 3,860 | $ 584 | 3.0% |
| Abdmnal Pain Unspcf Site | 18.3% | 11.9% | 5.8% | $ 2,077,663 | 5,465 | $ 380 | 2.8% |
| Benign Neoplasm Lg Bowel | 11.9% | 12.0% | -0.1% | $ 1,958,296 | 2,434 | $ 805 | 2.6% |
| Headache | 22.3% | 15.4% | 6.1% | $ 1,846,928 | 2,802 | $ 659 | 2.5% |
| Calculus Of Kidney | 23.4% | 16.6% | 5.8% | $ 1,819,003 | 2,445 | $ 744 | 2.4% |
| Screen Malig Neop-Colon | 34.5% | 35.2% | -0.5% | $ 1,667,268 | 2,764 | $ 603 | 2.2% |
| Hypertension Nos | 16.7% | 7.1% | 9.0% | $ 1,522,551 | 10,062 | $ 151 | 2.0% |
| Calculus Of Ureter | 8.7% | 3.4% | 5.2% | $ 1,519,820 | 915 | $ 1,661 | 2.0% |
| Atrial Fibrillation | 37.4% | 28.5% | 6.9% | $ 1,436,775 | 5,857 | $ 245 | 1.9% |
| Cholelith W Cholecys Nec | 19.4% | 5.3% | 13.4% | $ 1,425,602 | 365 | $ 3,906 | 1.9% |
| Hyperlipidemia Nec/Nos | 9.1% | 7.2% | 1.8% | $ 1,400,977 | 17,593 | $ 80 | 1.9% |
| Oth Lymp Unsp Xtrndl Org | 14.2% | 15.0% | -0.8% | $ 1,397,722 | 1,222 | $ 1,144 | 1.9% |
| Obstructive Sleep Apnea | 45.9% | 45.8% | 0.0% | $ 1,305,234 | 1,156 | $ 1,129 | 1.7% |
| End Stage Renal Disease | 59.8% | 20.2% | 32.9% | $ 1,291,164 | 368 | $ 3,509 | 1.7% |
| Regional Enteritis Nos | 20.7% | 2.8% | 17.4% | $ 1,213,798 | 927 | $ 1,309 | 1.6% |
| Dmii Wo Cmp Nt St Uncntr | 22.9% | 20.9% | 1.6% | $ 1,152,090 | 12,693 | $ 91 | 1.5% |
| Cervicalgia | 27.7% | 19.1% | 7.2% | $ 1,143,189 | 1,965 | $ 582 | 1.5% |
| Joint Pain-L/Leg | 17.3% | 11.6% | 5.1% | $ 1,140,333 | 2,779 | $ 410 | 1.5% |
| Mal Neo Bronch/Lung Nos | 1.0% | 13.0% | -10.6% | $ 1,135,277 | 1,265 | $ 897 | 1.5% |
| Malign Neopl Breast Nec | 35.8% | 12.2% | 21.0% | $ 1,061,043 | 1,174 | $ 904 | 1.4% |
| Anemia Nos | 30.5% | 14.5% | 14.1% | $ 1,052,166 | 6,111 | $ 172 | 1.4% |
| Rheumatoid Arthritis | 13.9% | 15.4% | -1.3% | $ 1,048,545 | 2,126 | $ 493 | 1.4% |
| Syncope And Collapse | 22.0% | 9.4% | 11.6% | $ 1,010,855 | 1,194 | $ 847 | 1.3% |
| Dizziness And Giddiness | 13.5% | 7.2% | 5.8% | $ 1,007,600 | 1,566 | $ 643 | 1.3% |
| Joint Pain-Shlder | 27.0% | 17.9% | 7.7% | $ 1,006,587 | 2,015 | $ 500 | 1.3% |
| Tear Med Menisc Knee-Cur | 12.8% | 4.7% | 7.7% | $ 999,488 | 628 | $ 1,592 | 1.3% |
| Pain In Limb | 13.5% | 10.1% | 3.0% | $ 988,031 | 3,348 | $ 295 | 1.3% |
| Malign Neopl Ovary | 5.5% | 27.0% | -17.0% | $ 984,617 | 1,331 | $ 740 | 1.3% |
| Screen Mal Neop-Cervix | 37.5% | 18.0% | 16.5% | $ 938,342 | 17,305 | $ 54 | 1.2% |
| Abdmnal Pain Oth Spcf St | 12.3% | 4.7% | 7.3% | $ 924,908 | 1,228 | $ 753 | 1.2% |
| Other Lung Disease Nec | 46.9% | 24.7% | 17.8% | $ 923,235 | 1,286 | $ 718 | 1.2% |
| Sprain Rotator Cuff | 19.6% | 7.5% | 11.3% | $ 921,404 | 586 | $ 1,572 | 1.2% |
| Excessive Menstruation | 0.6% | 9.5% | -8.1% | $ 919,628 | 1,083 | $ 849 | 1.2% |
| Rotator Cuff Synd Nos | 9.8% | 1.1% | 8.5% | $ 901,085 | 568 | $ 1,586 | 1.2% |
| Unilat Inguinal Hernia | 16.1% | 6.2% | 9.4% | $ 888,638 | 434 | $ 2,048 | 1.2% |
| Respiratory Abnorm Nec | 4.4% | 1.3% | 3.1% | $ 822,889 | 1,258 | $ 654 | 1.1% |
| Mal Neo Breast Up-Outer | 28.2% | -19.8% | 59.9% | $ 818,381 | 347 | $ 2,358 | 1.1% |
| Dvrtclo Colon W/O Hmrhg | 11.8% | 9.0% | 2.5% | $ 817,753 | 1,147 | $ 713 | 1.1% |
| Malaise And Fatigue Nec | 11.0% | 11.4% | -0.4% | $ 802,041 | 5,571 | $ 144 | 1.1% |
| Cataract Nos | 46.7% | 35.8% | 8.1% | $ 797,966 | 364 | $ 2,192 | 1.1% |
| Mult Myelm W/O Remission | 20.2% | 30.0% | -7.6% | $ 788,766 | 897 | $ 879 | 1.0% |
| Malignant Neo Colon Nos | -5.6% | 19.0% | -20.7% | $ 762,585 | 852 | $ 895 | 1.0% |
| Urin Tract Infection Nos | 8.6% | 16.4% | -6.7% | $ 757,662 | 8,422 | $ 90 | 1.0% |
| Top 50 Total | 20.0% | 14.0% | 5.2% | $ 75,244,917 | 178,624 | $ 421 | 34.9% |
| **Grand Total** | **18.8%** | **13.1%** | **5.0%** | **$ 215,644,018** | **526,658** | **$ 409** | **100.0%** |

# Appendix – C7

Hospital Provider Class – Outpatient

2006 Cost, Use, and Price Experience by Top 50 Diagnoses Codes

| Outpatient Hospital by Top 50 Diagnoses | Two year average rate of change Per 1000 Members | | | 2006 Payments | 2006 Visits | Avg Pmt/Vst | % of Total Payout |
|---|---|---|---|---|---|---|---|
| | Payments | Visits | Pmt/Vst | | | | |
| Malign Neopl Breast Nos | 59.2% | 21.8% | 30.7% | $ 5,789,790 | 6,104 | $ 949 | 6.4% |
| Chest Pain Nos | 13.1% | 2.1% | 10.8% | $ 5,564,227 | 6,001 | $ 927 | 6.1% |
| Antineoplastic Chemo Enc | 933.1% | 736.0% | 23.6% | $ 4,666,474 | 1,361 | $ 3,429 | 5.1% |
| Chest Pain Nec | 21.0% | 11.1% | 8.9% | $ 4,194,641 | 2,612 | $ 1,606 | 4.6% |
| Crnry Athrscl Natve Vssl | 24.7% | 16.9% | 6.6% | $ 3,431,139 | 2,199 | $ 1,560 | 3.8% |
| Screen Mammogram Nec | 30.8% | 12.7% | 16.0% | $ 3,066,261 | 30,518 | $ 100 | 3.4% |
| Malign Neopl Prostate | 24.1% | 23.7% | 0.3% | $ 2,583,173 | 3,040 | $ 850 | 2.8% |
| Lumbago | 26.0% | 14.7% | 9.9% | $ 2,909,827 | 5,361 | $ 543 | 3.2% |
| Abdmnal Pain Unspcf Site | 27.8% | 18.4% | 7.9% | $ 2,547,347 | 7,088 | $ 359 | 2.8% |
| Benign Neoplasm Lg Bowel | 21.2% | 8.7% | 11.6% | $ 2,539,913 | 3,154 | $ 805 | 2.8% |
| Headache | 16.6% | 5.5% | 10.6% | $ 2,190,280 | 3,524 | $ 622 | 2.4% |
| Calculus Of Kidney | 17.5% | 15.2% | 1.9% | $ 2,138,804 | 3,042 | $ 703 | 2.4% |
| Screen Malig Neop-Colon | 56.0% | 33.6% | 16.8% | $ 1,798,249 | 2,967 | $ 606 | 2.0% |
| Hypertension Nos | 22.3% | 19.0% | 2.7% | $ 1,892,217 | 13,633 | $ 139 | 2.1% |
| Calculus Of Ureter | 15.7% | 9.3% | 5.9% | $ 2,027,969 | 1,284 | $ 1,579 | 2.2% |
| Atrial Fibrillation | 155.7% | 30.1% | 96.6% | $ 1,516,973 | 6,613 | $ 229 | 1.7% |
| Cholelith W Cholecys Nec | 20.5% | 19.5% | 0.8% | $ 1,732,450 | 503 | $ 3,444 | 1.9% |
| Hyperlipidemia Nec/Nos | 19.0% | 8.8% | 9.4% | $ 1,862,658 | 23,821 | $ 78 | 2.0% |
| Oth Lymp Unsp Xtrndl Org | 15.9% | 1.9% | 13.7% | $ 1,776,055 | 1,541 | $ 1,153 | 2.0% |
| Obstructive Sleep Apnea | 542.3% | 551.3% | -1.4% | $ 1,298,054 | 1,150 | $ 1,129 | 1.4% |
| End Stage Renal Disease | 574.1% | 475.1% | 17.2% | $ 1,172,260 | 444 | $ 2,640 | 1.3% |
| Regional Enteritis Nos | 29.6% | 19.6% | 8.4% | $ 1,458,712 | 1,308 | $ 1,115 | 1.6% |
| Dmii Wo Cmp Nt St Uncntr | 27.5% | 20.3% | 5.9% | $ 1,359,668 | 15,226 | $ 89 | 1.5% |
| Cervicalgia | 21.0% | 12.2% | 7.9% | $ 1,299,021 | 2,393 | $ 543 | 1.4% |
| Joint Pain-L/Leg | 29.9% | 15.3% | 12.7% | $ 1,410,041 | 3,612 | $ 390 | 1.5% |
| Mal Neo Bronch/Lung Nos | 27.6% | 8.7% | 17.4% | $ 1,630,477 | 1,624 | $ 1,004 | 1.8% |
| Malign Neopl Breast Nec | 90.8% | 37.8% | 38.4% | $ 1,133,453 | 1,518 | $ 747 | 1.2% |
| Anemia Nos | 29.0% | 9.1% | 18.2% | $ 1,169,366 | 7,746 | $ 151 | 1.3% |
| Rheumatoid Arthritis | 42.8% | 19.3% | 19.7% | $ 1,336,060 | 2,673 | $ 500 | 1.5% |
| Syncope And Collapse | 28.4% | 13.9% | 12.8% | $ 1,201,847 | 1,584 | $ 759 | 1.3% |
| Dizziness And Giddiness | 34.5% | 13.2% | 18.8% | $ 1,288,156 | 2,119 | $ 608 | 1.4% |
| Joint Pain-Shlder | 29.0% | 13.5% | 13.6% | $ 1,149,985 | 2,479 | $ 464 | 1.3% |
| Tear Med Menisc Knee-Cur | 26.6% | 8.1% | 17.2% | $ 1,285,800 | 870 | $ 1,478 | 1.4% |
| Pain In Limb | 28.1% | 14.5% | 11.9% | $ 1,262,993 | 4,410 | $ 286 | 1.4% |
| Malign Neopl Ovary | 121.2% | 46.9% | 50.6% | $ 1,354,084 | 1,520 | $ 891 | 1.5% |
| Screen Mal Neop-Cervix | 18.1% | 10.8% | 6.6% | $ 990,382 | 21,276 | $ 47 | 1.1% |
| Abdmnal Pain Oth Spcf St | 18.1% | 13.0% | 4.5% | $ 1,194,918 | 1,702 | $ 702 | 1.3% |
| Other Lung Disease Nec | 22.7% | 18.4% | 3.6% | $ 911,523 | 1,496 | $ 609 | 1.0% |
| Sprain Rotator Cuff | 44.9% | 21.5% | 19.3% | $ 1,117,260 | 791 | $ 1,412 | 1.2% |
| Excessive Menstruation | 30.5% | 13.5% | 14.9% | $ 1,325,946 | 1,435 | $ 924 | 1.5% |
| Rotator Cuff Synd Nos | 13.0% | 7.0% | 5.6% | $ 1,191,168 | 815 | $ 1,462 | 1.3% |
| Unilat Inguinal Hernia | -0.9% | -1.2% | 0.3% | $ 1,110,197 | 593 | $ 1,872 | 1.2% |
| Respiratory Abnorm Nec | 32.1% | 17.9% | 12.0% | $ 1,143,825 | 1,802 | $ 635 | 1.3% |
| Mal Neo Breast Up-Outer | 27.8% | 57.1% | -18.7% | $ 926,048 | 628 | $ 1,475 | 1.0% |
| Dvrtclo Colon W/O Hmrhg | 12.8% | 1.1% | 11.6% | $ 1,061,257 | 1,526 | $ 695 | 1.2% |
| Malaise And Fatigue Nec | 25.4% | 12.9% | 11.1% | $ 1,048,634 | 7,257 | $ 144 | 1.2% |
| Cataract Nos | 20.9% | 13.0% | 7.0% | $ 789,075 | 389 | $ 2,028 | 0.9% |
| Mult Myelm W/O Remission | 48.5% | 35.6% | 9.5% | $ 952,206 | 1,001 | $ 951 | 1.0% |
| Malignant Neo Colon Nos | 21.1% | 22.3% | -1.0% | $ 1,172,476 | 1,039 | $ 1,128 | 1.3% |
| Urin Tract Infection Nos | 34.5% | 13.2% | 18.8% | $ 1,012,099 | 10,497 | $ 96 | 1.1% |
| Top 50 Total | 37.6% | 15.5% | 19.2% | $ 90,985,438 | 227,289 | $ 400 | 34.6% |
| **Grand Total** | **23.0%** | **12.2%** | **9.7%** | **$ 263,321,669** | **675,396** | **$ 390** | **100.0%** |

## Appendix – C8

Hospital Provider Class – Outpatient

2005 Cost, Use, and Price Experience by Top 50 Diagnoses

| Outpatient Hospital by Top 50 Diagnoses | 2005 Payments | 2005 Visits | Avg Pmt/Vst | % of Total Payout |
|---|---|---|---|---|
| Malign Neopl Breast Nos | $ 6,077,649 | 8,372 | $ 726 | 5.5% |
| Chest Pain Nos | $ 8,220,120 | 9,822 | $ 837 | 7.4% |
| Antineoplastic Chemo Enc | $ 754,679 | 272 | $ 2,775 | 0.7% |
| Chest Pain Nec | $ 5,791,214 | 3,927 | $ 1,475 | 5.2% |
| Crnry Athrscl Natve Vssl | $ 4,598,819 | 3,143 | $ 1,463 | 4.2% |
| Screen Mammogram Nec | $ 3,917,084 | 45,228 | $ 87 | 3.5% |
| Malign Neopl Prostate | $ 3,478,099 | 4,106 | $ 847 | 3.1% |
| Lumbago | $ 3,857,565 | 7,811 | $ 494 | 3.5% |
| Abdmnal Pain Unspcf Site | $ 3,331,137 | 10,005 | $ 333 | 3.0% |
| Benign Neoplasm Lg Bowel | $ 3,500,325 | 4,849 | $ 722 | 3.2% |
| Headache | $ 3,138,850 | 5,583 | $ 562 | 2.8% |
| Calculus Of Kidney | $ 3,042,145 | 4,411 | $ 690 | 2.8% |
| Screen Malig Neop-Colon | $ 1,925,664 | 3,711 | $ 519 | 1.7% |
| Hypertension Nos | $ 2,585,959 | 19,139 | $ 135 | 2.3% |
| Calculus Of Ureter | $ 2,927,483 | 1,962 | $ 1,492 | 2.7% |
| Atrial Fibrillation | $ 991,351 | 8,495 | $ 117 | 0.9% |
| Cholelith W Cholecys Nec | $ 2,402,858 | 703 | $ 3,418 | 2.2% |
| Hyperlipidemia Nec/Nos | $ 2,614,297 | 36,582 | $ 71 | 2.4% |
| Oth Lymp Unsp Xtrndl Org | $ 2,561,153 | 2,527 | $ 1,014 | 2.3% |
| Obstructive Sleep Apnea | $ 337,648 | 295 | $ 1,145 | 0.3% |
| End Stage Renal Disease | $ 290,552 | 129 | $ 2,252 | 0.3% |
| Regional Enteritis Nos | $ 1,880,457 | 1,827 | $ 1,029 | 1.7% |
| Dmii Wo Cmp Nt St Uncntr | $ 1,782,156 | 21,140 | $ 84 | 1.6% |
| Cervicalgia | $ 1,793,081 | 3,564 | $ 503 | 1.6% |
| Joint Pain-L/Leg | $ 1,813,355 | 5,235 | $ 346 | 1.6% |
| Mal Neo Bronch/Lung Nos | $ 2,135,005 | 2,497 | $ 855 | 1.9% |
| Malign Neopl Breast Nec | $ 992,505 | 1,840 | $ 539 | 0.9% |
| Anemia Nos | $ 1,514,919 | 11,861 | $ 128 | 1.4% |
| Rheumatoid Arthritis | $ 1,563,306 | 3,745 | $ 417 | 1.4% |
| Syncope And Collapse | $ 1,563,772 | 2,324 | $ 673 | 1.4% |
| Dizziness And Giddiness | $ 1,600,460 | 3,128 | $ 512 | 1.4% |
| Joint Pain-Shlder | $ 1,489,264 | 3,648 | $ 408 | 1.3% |
| Tear Med Menisc Knee-Cur | $ 1,696,286 | 1,345 | $ 1,261 | 1.5% |
| Pain In Limb | $ 1,647,361 | 6,434 | $ 256 | 1.5% |
| Malign Neopl Ovary | $ 1,022,580 | 1,729 | $ 591 | 0.9% |
| Screen Mal Neop-Cervix | $ 1,401,166 | 32,079 | $ 44 | 1.3% |
| Abdmnal Pain Oth Spcf St | $ 1,690,108 | 2,516 | $ 672 | 1.5% |
| Other Lung Disease Nec | $ 1,241,659 | 2,111 | $ 588 | 1.1% |
| Sprain Rotator Cuff | $ 1,288,092 | 1,088 | $ 1,184 | 1.2% |
| Excessive Menstruation | $ 1,697,878 | 2,112 | $ 804 | 1.5% |
| Rotator Cuff Synd Nos | $ 1,761,800 | 1,273 | $ 1,384 | 1.6% |
| Unilat Inguinal Hernia | $ 1,872,727 | 1,003 | $ 1,867 | 1.7% |
| Respiratory Abnorm Nec | $ 1,446,870 | 2,553 | $ 567 | 1.3% |
| Mal Neo Breast Up-Outer | $ 1,211,103 | 668 | $ 1,813 | 1.1% |
| Dvrtclo Colon W/O Hmrhg | $ 1,572,094 | 2,522 | $ 623 | 1.4% |
| Malaise And Fatigue Nec | $ 1,397,097 | 10,743 | $ 130 | 1.3% |
| Cataract Nos | $ 1,090,454 | 575 | $ 1,896 | 1.0% |
| Mult Myelm W/O Remission | $ 1,071,538 | 1,233 | $ 869 | 1.0% |
| Malignant Neo Colon Nos | $ 1,617,820 | 1,420 | $ 1,139 | 1.5% |
| Urin Tract Infection Nos | $ 1,257,470 | 15,489 | $ 81 | 1.1% |
| Top 50 Total | $ 110,457,036 | 328,774 | $ 336 | 30.9% |
| **Grand Total** | **$ 357,613,525** | **1,005,813** | **$ 356** | **100.0%** |

# Appendix – C9

Hospital Provider Class – Inpatient

2007 Cost, Use, and Price Experience by Top 50 Diagnoses

| Inpatient Hospital by Top 50 Diagnoses | Two year average rate of change Per 1000 Members | | | 2007 Payments | 2007 Days | 2007 Adm | 2007 Avg Pmt/Day | 2007 Avg Pmt/Adm | Pct to Total Payout |
|---|---|---|---|---|---|---|---|---|---|
| | Payments | Days | Pmt/Adm | | | | | | |
| Crnry Athrscl Natve Vssl | 8.8% | 8.0% | 11.2% | $ 11,692,510 | 1,829 | 630 | $ 6,393 | $ 18,560 | 5.4% |
| Loc Osteoarth Nos-L/Leg | 39.4% | 23.9% | 11.0% | $ 7,318,169 | 1,184 | 380 | $ 6,181 | $ 19,258 | 3.4% |
| Rehabilitation Proc Nec | 37.3% | 28.6% | 1.3% | $ 4,282,294 | 3,235 | 258 | $ 1,324 | $ 16,598 | 2.0% |
| Subendo Infarct, Initial | 13.9% | 6.4% | 3.9% | $ 3,898,863 | 808 | 189 | $ 4,825 | $ 20,629 | 1.8% |
| Morbid Obesity | 11.1% | 6.1% | 18.8% | $ 3,707,633 | 556 | 241 | $ 6,668 | $ 15,384 | 1.7% |
| Loc Osteoarth Nos-Pelvis | 56.3% | 33.6% | 10.8% | $ 3,321,843 | 559 | 180 | $ 5,942 | $ 18,455 | 1.5% |
| Septicemia Nos | 42.3% | 10.9% | 14.5% | $ 2,974,931 | 1,224 | 167 | $ 2,430 | $ 17,814 | 1.4% |
| Chf Nos | 15.1% | -0.3% | 24.9% | $ 2,874,210 | 824 | 155 | $ 3,488 | $ 18,543 | 1.3% |
| Osteoarthros Nos-L/Leg | 30.3% | 8.5% | 18.1% | $ 2,592,570 | 398 | 130 | $ 6,514 | $ 19,943 | 1.2% |
| Acute Respiratry Failure | 4.5% | -3.2% | -7.7% | $ 2,503,496 | 834 | 103 | $ 3,002 | $ 24,306 | 1.2% |
| Pneumonia, Organism Nos | 12.0% | 5.1% | 3.7% | $ 2,480,879 | 1,243 | 312 | $ 1,996 | $ 7,952 | 1.1% |
| Single Lb In-Hosp W/O Cs | 237.1% | 421.6% | -81.1% | $ 2,407,510 | 2,193 | 1,268 | $ 1,098 | $ 1,899 | 1.1% |
| Lumbar Disc Displacement | 31.3% | 16.5% | 16.2% | $ 2,129,320 | 480 | 226 | $ 4,436 | $ 9,422 | 1.0% |
| Dvrtcli Colon W/O Hmrhg | 24.5% | 34.4% | 3.0% | $ 1,896,427 | 978 | 200 | $ 1,939 | $ 9,482 | 0.9% |
| Single Lb In-Hosp W Cs | 63.7% | 148.2% | -81.4% | $ 1,819,919 | 1,661 | 631 | $ 1,096 | $ 2,884 | 0.8% |
| Other Postop Infection | 62.2% | 26.8% | 38.4% | $ 1,797,103 | 782 | 118 | $ 2,298 | $ 15,230 | 0.8% |
| Act Myl Leuk W/O Rmsion | 171.7% | 26.6% | 157.5% | $ 1,794,490 | 356 | 16 | $ 5,041 | $ 112,156 | 0.8% |
| Subarachnoid Hemorrhage | 88.4% | 74.3% | 23.7% | $ 1,669,163 | 346 | 21 | $ 4,824 | $ 79,484 | 0.8% |
| Acute Pancreatitis | 48.6% | 24.5% | -4.0% | $ 1,658,157 | 981 | 191 | $ 1,690 | $ 8,681 | 0.8% |
| Malign Neopl Prostate | 49.3% | 40.8% | 13.8% | $ 1,608,939 | 297 | 142 | $ 5,417 | $ 11,331 | 0.7% |
| Antineoplastic Chemo Enc | 46.1% | 29.2% | 41.6% | $ 1,608,198 | 722 | 118 | $ 2,227 | $ 13,629 | 0.7% |
| Acute Renal Failure Nos | 43.6% | 46.8% | -4.7% | $ 1,528,814 | 748 | 136 | $ 2,044 | $ 11,241 | 0.7% |
| Osteoarthros Nos-Pelvis | 68.9% | 38.8% | 7.4% | $ 1,525,673 | 242 | 77 | $ 6,304 | $ 19,814 | 0.7% |
| Atrial Fibrillation | -13.7% | 1.9% | -3.9% | $ 1,441,678 | 594 | 197 | $ 2,427 | $ 7,318 | 0.7% |
| Obs Chr Bronc W(Ac) Exac | 130.1% | 44.6% | 88.9% | $ 1,431,582 | 564 | 110 | $ 2,538 | $ 13,014 | 0.7% |
| Prev C-Delivery-Delivrd | 3.6% | 15.1% | -10.3% | $ 1,412,533 | 690 | 265 | $ 2,047 | $ 5,330 | 0.6% |
| Pulm Embol/Infarct Nec | 38.6% | 22.5% | -1.1% | $ 1,283,420 | 625 | 113 | $ 2,053 | $ 11,358 | 0.6% |
| Spinal Stenosis-Lumbar | 38.0% | 17.3% | 13.3% | $ 1,164,365 | 245 | 84 | $ 4,753 | $ 13,861 | 0.5% |
| Recur Depr Psych-Severe | 41.8% | 32.7% | 8.7% | $ 1,118,406 | 1,222 | 233 | $ 915 | $ 4,800 | 0.5% |
| Ami Inferior Wall, Init | 7.9% | -17.8% | -6.1% | $ 1,090,673 | 158 | 57 | $ 6,903 | $ 19,135 | 0.5% |
| Crbl Art Ocl Nos W Infrc | 19.1% | 5.4% | 8.4% | $ 1,060,149 | 409 | 100 | $ 2,592 | $ 10,601 | 0.5% |
| Chest Pain Nec | 31.8% | 10.6% | 14.8% | $ 1,050,850 | 324 | 178 | $ 3,243 | $ 5,904 | 0.5% |
| Dsct Of Thoracic Aorta | 1538.2% | 971.7% | 142.0% | $ 947,837 | 229 | 14 | $ 4,139 | $ 67,703 | 0.4% |
| Loc Prim Osteoart-L/Leg | 59.4% | 26.7% | 18.5% | $ 931,696 | 159 | 51 | $ 5,860 | $ 18,269 | 0.4% |
| Acute Appendicitis Nos | 9.9% | -2.5% | 6.6% | $ 926,435 | 252 | 150 | $ 3,676 | $ 6,176 | 0.4% |
| Intestinal Adhes W Obstr | 40.4% | 47.7% | 12.9% | $ 916,945 | 458 | 54 | $ 2,002 | $ 16,980 | 0.4% |
| Ocl Crtd Art Wo Infrct | 52.3% | 10.5% | 12.9% | $ 898,786 | 128 | 79 | $ 7,022 | $ 11,377 | 0.4% |
| Malig Neo Corpus Uteri | 158.2% | 123.2% | 59.6% | $ 865,255 | 260 | 58 | $ 3,328 | $ 14,918 | 0.4% |
| Sec Mal Neo Brain/Spine | 96.9% | 111.0% | 6.9% | $ 838,847 | 285 | 47 | $ 2,943 | $ 17,848 | 0.4% |
| Cervical Disc Displacmnt | 0.8% | 1.1% | -3.8% | $ 827,441 | 131 | 86 | $ 6,316 | $ 9,621 | 0.4% |
| React-Oth Vasc Dev/Graft | 15.5% | 9.4% | 9.5% | $ 827,063 | 515 | 56 | $ 1,606 | $ 14,769 | 0.4% |
| Aortic Valve Disorder | 6.6% | -20.4% | 15.5% | $ 806,655 | 135 | 21 | $ 5,975 | $ 38,412 | 0.4% |
| Mitral Valve Disorder | 49.1% | 47.1% | 33.0% | $ 764,544 | 143 | 17 | $ 5,346 | $ 44,973 | 0.4% |
| Food/Vomit Pneumonitis | 86.5% | 68.2% | 22.6% | $ 761,932 | 342 | 43 | $ 2,228 | $ 17,719 | 0.4% |
| Cellulitis Of Leg | 33.0% | -0.6% | 9.5% | $ 758,577 | 522 | 129 | $ 1,453 | $ 5,880 | 0.3% |
| Cholelith W Ac Cholecyst | 97.9% | 25.9% | 32.4% | $ 754,996 | 203 | 69 | $ 3,719 | $ 10,942 | 0.3% |
| Acq Spondylolisthesis | 62.3% | 28.6% | 24.6% | $ 740,798 | 125 | 35 | $ 5,926 | $ 21,166 | 0.3% |
| Intramural Leiomyoma | 11.3% | 0.5% | 12.6% | $ 732,463 | 223 | 92 | $ 3,285 | $ 7,962 | 0.3% |
| Ami Anterior Wall, Init | -6.6% | -23.5% | -3.4% | $ 729,781 | 126 | 28 | $ 5,792 | $ 26,064 | 0.3% |
| Abdom Aortic Aneurysm | 80.9% | 39.9% | -0.2% | $ 710,206 | 81 | 25 | $ 8,768 | $ 28,408 | 0.3% |
| Other | 23.0% | 16.7% | 8.6% | $ 122,749,149 | 52,243 | 12,412 | $ 2,350 | $ 9,890 | 56.4% |
| Top 50 Diagnosis | 33.8% | 30.5% | -8.8% | $ 94,885,022 | 31,628 | 8,280 | $ 3,000 | $ 11,460 | 43.6% |
| **GRAND TOTAL** | **27.5%** | **24.6%** | **2.3%** | **$ 217,634,171** | **83,871** | **20,692** | **$ 2,595** | **$ 10,518** | **100%** |

# Appendix – C10

Hospital Provider Class – Inpatient

2006 Cost, Use, and Price Experience by Top 50 Diagnoses

| Inpatient Hospital by Top 50 Diagnoses | Two year average rate of change Per 1000 Members | | | 2006 Payments | 2006 Days | 2006 Adm | 2006 Avg Pmt/Day | 2006 Avg Pmt/Adm | Pct to Total Payout |
|---|---|---|---|---|---|---|---|---|---|
| | Payments | Days | Pmt/Adm | | | | | | |
| Crnry Athrscl Natve Vssl | 6.3% | -4.4% | 6.9% | $ 15,592,475 | 2,458 | 934 | $ 6,344 | $ 16,694 | 6.3% |
| Loc Osteoarth Nos-L/Leg | 19.5% | 10.2% | 8.5% | $ 7,614,903 | 1,386 | 439 | $ 5,494 | $ 17,346 | 3.1% |
| Subendo Infarct, Initial | 19.5% | 13.8% | 17.3% | $ 4,965,280 | 1,102 | 250 | $ 4,506 | $ 19,861 | 2.0% |
| Morbid Obesity | 13.6% | -9.7% | 1.5% | $ 4,843,002 | 760 | 374 | $ 6,372 | $ 12,949 | 2.0% |
| Rehabilitation Proc Nec | 23.9% | 18.2% | 16.3% | $ 4,523,961 | 3,649 | 276 | $ 1,240 | $ 16,391 | 1.8% |
| Chf Nos | 9.1% | 6.3% | -8.7% | $ 3,621,607 | 1,199 | 244 | $ 3,021 | $ 14,843 | 1.5% |
| Acute Respiratry Failure | 26.6% | 28.6% | -0.7% | $ 3,475,021 | 1,250 | 132 | $ 2,780 | $ 26,326 | 1.4% |
| Pneumonia, Organism Nos | 14.0% | 1.7% | 19.3% | $ 3,214,085 | 1,716 | 419 | $ 1,873 | $ 7,671 | 1.3% |
| Loc Osteoarth Nos-Pelvis | 12.4% | 4.8% | 5.8% | $ 3,082,456 | 607 | 185 | $ 5,078 | $ 16,662 | 1.2% |
| Septicemia Nos | 90.8% | 81.8% | 21.2% | $ 3,032,575 | 1,601 | 195 | $ 1,894 | $ 15,552 | 1.2% |
| Osteoarthros Nos-L/Leg | 22.5% | 4.7% | 5.4% | $ 2,887,785 | 532 | 171 | $ 5,428 | $ 16,888 | 1.2% |
| Atrial Fibrillation | 28.8% | 9.9% | 11.0% | $ 2,422,745 | 846 | 318 | $ 2,864 | $ 7,619 | 1.0% |
| Lumbar Disc Displacement | 17.9% | 15.8% | 5.1% | $ 2,352,141 | 598 | 290 | $ 3,933 | $ 8,111 | 0.9% |
| Dvrtcli Colon W/O Hmrhg | 32.5% | 7.8% | 16.6% | $ 2,209,568 | 1,056 | 240 | $ 2,092 | $ 9,207 | 0.9% |
| Prev C-Delivery-Delivrd | 4.7% | 2.5% | 2.4% | $ 1,977,778 | 870 | 333 | $ 2,273 | $ 5,939 | 0.8% |
| Acute Pancreatitis | 5.5% | 20.9% | 2.7% | $ 1,619,107 | 1,143 | 179 | $ 1,417 | $ 9,045 | 0.7% |
| Single Lb In-Hosp W Cs | -27.7% | -23.4% | -29.6% | $ 1,612,954 | 971 | 104 | $ 1,661 | $ 15,509 | 0.7% |
| Other Postop Infection | 24.2% | 26.9% | 8.9% | $ 1,607,011 | 895 | 146 | $ 1,796 | $ 11,007 | 0.6% |
| Antineoplastic Chemo Enc | 479.8% | 375.5% | -12.2% | $ 1,597,320 | 811 | 166 | $ 1,970 | $ 9,622 | 0.6% |
| Malign Neopl Prostate | 11.6% | -6.7% | 3.8% | $ 1,563,863 | 306 | 157 | $ 5,111 | $ 9,961 | 0.6% |
| Acute Renal Failure Nos | 26.2% | 4.4% | 13.0% | $ 1,545,092 | 739 | 131 | $ 2,091 | $ 11,795 | 0.6% |
| Ami Inferior Wall, Init | 5.7% | 5.5% | 2.8% | $ 1,466,931 | 279 | 72 | $ 5,258 | $ 20,374 | 0.6% |
| Pulm Embol/Infarct Nec | 31.7% | 33.2% | 7.1% | $ 1,342,978 | 740 | 117 | $ 1,815 | $ 11,478 | 0.5% |
| Osteoarthros Nos-Pelvis | 61.1% | 35.1% | 15.5% | $ 1,310,190 | 253 | 71 | $ 5,179 | $ 18,453 | 0.5% |
| Crbl Art Ocl Nos W Infrc | 3.4% | -4.0% | -1.6% | $ 1,291,516 | 563 | 132 | $ 2,294 | $ 9,784 | 0.5% |
| Subarachnoid Hemorrhage | 56.9% | 41.5% | 40.8% | $ 1,285,358 | 288 | 20 | $ 4,463 | $ 64,268 | 0.5% |
| Spinal Stenosis-Lumbar | 10.6% | 2.7% | 7.2% | $ 1,223,752 | 303 | 100 | $ 4,039 | $ 12,238 | 0.5% |
| Acute Appendicitis Nos | 23.4% | 13.5% | 8.8% | $ 1,222,571 | 375 | 211 | $ 3,260 | $ 5,794 | 0.5% |
| Cervical Disc Displacmnt | 41.6% | 24.6% | 18.2% | $ 1,190,693 | 188 | 119 | $ 6,333 | $ 10,006 | 0.5% |
| Chest Pain Nec | 1.4% | -2.3% | -0.4% | $ 1,157,085 | 425 | 225 | $ 2,723 | $ 5,143 | 0.5% |
| Recur Depr Psych-Severe | 50.8% | 34.6% | 19.5% | $ 1,143,982 | 1,336 | 259 | $ 856 | $ 4,417 | 0.5% |
| Ami Anterior Wall, Init | 1.0% | -15.4% | 15.2% | $ 1,133,711 | 239 | 42 | $ 4,744 | $ 26,993 | 0.5% |
| Aortic Valve Disorder | 24.1% | 67.8% | -5.5% | $ 1,097,781 | 246 | 33 | $ 4,463 | $ 33,266 | 0.4% |
| React-Oth Vasc Dev/Graft | 68.6% | 80.0% | 6.1% | $ 1,038,817 | 683 | 77 | $ 1,521 | $ 13,491 | 0.4% |
| Single Lb In-Hosp W/O Cs | 16.8% | 7.6% | 12.0% | $ 1,036,104 | 610 | 103 | $ 1,699 | $ 10,059 | 0.4% |
| Act Myl Leuk W/O Rmsion | 26.0% | 14.4% | -17.7% | $ 958,205 | 408 | 22 | $ 2,349 | $ 43,555 | 0.4% |
| Intramural Leiomyoma | 12.9% | -2.9% | 7.1% | $ 954,717 | 322 | 135 | $ 2,965 | $ 7,072 | 0.4% |
| Intestinal Adhes W Obstr | 29.4% | -3.4% | 19.3% | $ 947,280 | 450 | 63 | $ 2,105 | $ 15,036 | 0.4% |
| Obs Chr Bronc W(Ac) Exac | -11.9% | -16.8% | -11.4% | $ 902,744 | 566 | 131 | $ 1,595 | $ 6,891 | 0.4% |
| Ocl Crtd Art Wo Infrct | 4.6% | 4.3% | 6.8% | $ 856,286 | 168 | 85 | $ 5,097 | $ 10,074 | 0.3% |
| Loc Prim Osteoart-L/Leg | 8.8% | 16.5% | -3.0% | $ 847,928 | 182 | 55 | $ 4,659 | $ 15,417 | 0.3% |
| Cellulitis Of Leg | 18.5% | 23.2% | 6.0% | $ 827,353 | 762 | 154 | $ 1,086 | $ 5,372 | 0.3% |
| Mitral Valve Disorder | -8.6% | 13.8% | -15.4% | $ 743,767 | 141 | 22 | $ 5,275 | $ 33,808 | 0.3% |
| Acq Spondylolisthesis | 10.1% | 12.7% | -2.0% | $ 662,376 | 141 | 39 | $ 4,698 | $ 16,984 | 0.3% |
| Sec Mal Neo Brain/Spine | -14.5% | -23.3% | 17.5% | $ 618,030 | 196 | 37 | $ 3,153 | $ 16,704 | 0.2% |
| Food/Vomit Pneumonitis | 7.6% | -18.8% | 0.5% | $ 592,626 | 295 | 41 | $ 2,009 | $ 14,454 | 0.2% |
| Abdom Aortic Aneurysm | -30.0% | -53.7% | -16.2% | $ 569,475 | 84 | 20 | $ 6,779 | $ 28,474 | 0.2% |
| Cholelith W Ac Cholecyst | 16.7% | 30.8% | -4.1% | $ 553,625 | 234 | 67 | $ 2,366 | $ 8,263 | 0.2% |
| Malig Neo Corpus Uteri | -13.2% | -19.6% | 0.9% | $ 486,202 | 169 | 52 | $ 2,877 | $ 9,350 | 0.2% |
| Dsct Of Thoracic Aorta | -77.8% | -78.3% | -29.3% | $ 83,940 | 31 | 3 | $ 2,708 | $ 27,980 | 0.0% |
| Other | 3.2% | -3.8% | 8.7% | $ 144,728,512 | 64,921 | 15,899 | $ 2,229 | $ 9,103 | 58.4% |
| Top 50 Diagnosis | 16.6% | 11.8% | 5.6% | $ 102,906,755 | 35,172 | 8,190 | $ 2,926 | $ 12,565 | 41.6% |
| **GRAND TOTAL** | **17.9%** | **11.1%** | **7.5%** | **$ 247,635,267** | **100,093** | **24,089** | **$ 2,474** | **$ 10,280** | **100%** |

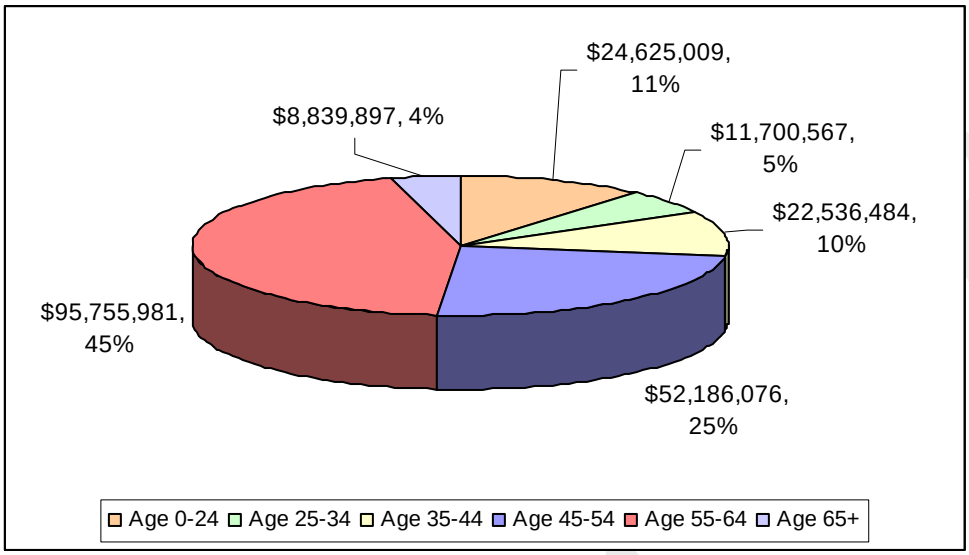
# Appendix – C11

Hospital Provider Class – Inpatient

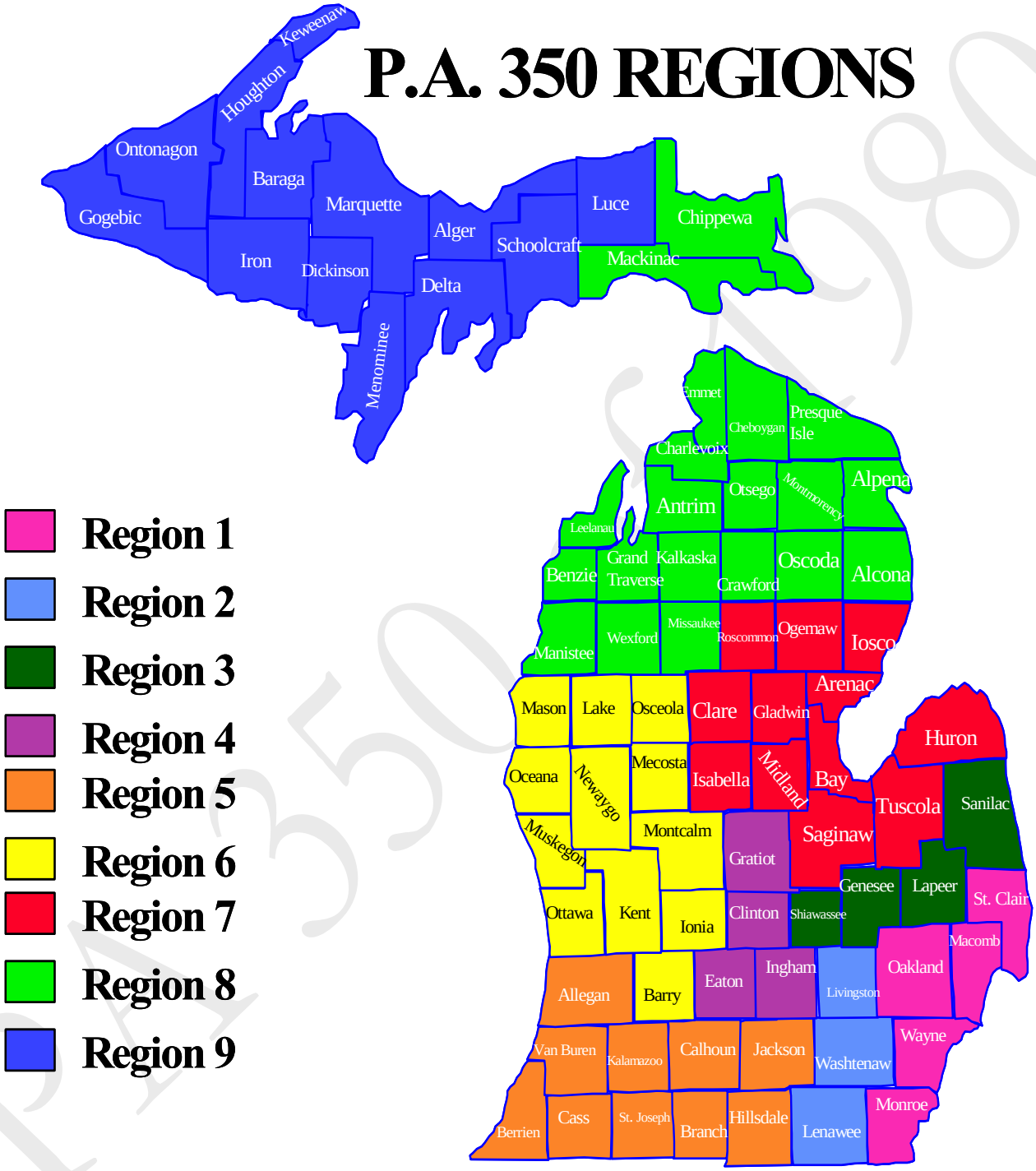
2005 Cost, Use, and Price Experience by Top 50 Diagnoses

| Inpatient Hospital by Top 50 Diagnoses | 2005 Payments | 2005 Days | 2005 Adm | 2005 Avg Pmt/Day | 2005 Avg Pmt/Adm | Pct to Total Payout |
|---|---|---|---|---|---|---|
| Crnry Athrscl Natve Vssl | $ 24,497,985 | 4,295 | 1,568 | $ 5,704 | $ 15,624 | 7.0% |
| Loc Osteoarth Nos-L/Leg | $ 10,642,945 | 2,101 | 666 | $ 5,066 | $ 15,980 | 3.0% |
| Morbid Obesity | $ 7,121,366 | 1,406 | 558 | $ 5,065 | $ 12,762 | 2.0% |
| Subendo Infarct, Initial | $ 6,943,500 | 1,618 | 410 | $ 4,291 | $ 16,935 | 2.0% |
| Rehabilitation Proc Nec | $ 6,102,582 | 5,158 | 433 | $ 1,183 | $ 14,094 | 1.7% |
| Chf Nos | $ 5,546,241 | 1,884 | 341 | $ 2,944 | $ 16,265 | 1.6% |
| Pneumonia, Organism Nos | $ 4,711,179 | 2,819 | 733 | $ 1,671 | $ 6,427 | 1.3% |
| Acute Respiratry Failure | $ 4,588,003 | 1,624 | 173 | $ 2,825 | $ 26,520 | 1.3% |
| Loc Osteoarth Nos-Pelvis | $ 4,581,988 | 968 | 291 | $ 4,733 | $ 15,746 | 1.3% |
| Osteoarthros Nos-L/Leg | $ 3,939,739 | 849 | 246 | $ 4,640 | $ 16,015 | 1.1% |
| Single Lb In-Hosp W Cs | $ 3,725,424 | 2,118 | 169 | $ 1,759 | $ 22,044 | 1.1% |
| Lumbar Disc Displacement | $ 3,333,803 | 863 | 432 | $ 3,863 | $ 7,717 | 1.0% |
| Prev C-Delivery-Delivrd | $ 3,154,875 | 1,418 | 544 | $ 2,225 | $ 5,799 | 0.9% |
| Atrial Fibrillation | $ 3,143,347 | 1,286 | 458 | $ 2,444 | $ 6,863 | 0.9% |
| Dvrtcli Colon W/O Hmrhg | $ 2,786,821 | 1,637 | 353 | $ 1,702 | $ 7,895 | 0.8% |
| Septicemia Nos | $ 2,655,616 | 1,471 | 207 | $ 1,805 | $ 12,829 | 0.8% |
| Acute Pancreatitis | $ 2,563,681 | 1,579 | 291 | $ 1,624 | $ 8,810 | 0.7% |
| Malign Neopl Prostate | $ 2,342,339 | 548 | 244 | $ 4,274 | $ 9,600 | 0.7% |
| Ami Inferior Wall, Init | $ 2,319,729 | 442 | 117 | $ 5,248 | $ 19,827 | 0.7% |
| Other Postop Infection | $ 2,162,001 | 1,178 | 214 | $ 1,835 | $ 10,103 | 0.6% |
| Crbl Art Ocl Nos W Infrc | $ 2,087,613 | 980 | 210 | $ 2,130 | $ 9,941 | 0.6% |
| Acute Renal Failure Nos | $ 2,046,275 | 1,183 | 196 | $ 1,730 | $ 10,440 | 0.6% |
| Chest Pain Nec | $ 1,905,719 | 727 | 369 | $ 2,621 | $ 5,165 | 0.5% |
| Ami Anterior Wall, Init | $ 1,874,773 | 472 | 80 | $ 3,972 | $ 23,435 | 0.5% |
| Spinal Stenosis-Lumbar | $ 1,849,424 | 493 | 162 | $ 3,751 | $ 11,416 | 0.5% |
| Obs Chr Bronc W(Ac) Exac | $ 1,711,618 | 1,137 | 220 | $ 1,505 | $ 7,780 | 0.5% |
| Pulm Embol/Infarct Nec | $ 1,703,634 | 928 | 159 | $ 1,836 | $ 10,715 | 0.5% |
| Acute Appendicitis Nos | $ 1,655,689 | 552 | 311 | $ 2,999 | $ 5,324 | 0.5% |
| Single Lb In-Hosp W/O Cs | $ 1,482,320 | 947 | 165 | $ 1,565 | $ 8,984 | 0.4% |
| Aortic Valve Disorder | $ 1,478,125 | 245 | 42 | $ 6,033 | $ 35,193 | 0.4% |
| Intramural Leiomyoma | $ 1,412,494 | 554 | 214 | $ 2,550 | $ 6,600 | 0.4% |
| Cervical Disc Displacmnt | $ 1,405,369 | 252 | 166 | $ 5,577 | $ 8,466 | 0.4% |
| Subarachnoid Hemorrhage | $ 1,369,186 | 340 | 30 | $ 4,027 | $ 45,640 | 0.4% |
| Ocl Crtd Art Wo Infrct | $ 1,367,622 | 269 | 145 | $ 5,084 | $ 9,432 | 0.4% |
| Mitral Valve Disorder | $ 1,359,288 | 207 | 34 | $ 6,567 | $ 39,979 | 0.4% |
| Osteoarthros Nos-Pelvis | $ 1,358,620 | 313 | 85 | $ 4,341 | $ 15,984 | 0.4% |
| Abdom Aortic Aneurysm | $ 1,358,401 | 303 | 40 | $ 4,483 | $ 33,960 | 0.4% |
| Loc Prim Osteoart-L/Leg | $ 1,302,622 | 261 | 82 | $ 4,991 | $ 15,886 | 0.4% |
| Act Myl Leuk W/O Rmsion | $ 1,270,167 | 596 | 24 | $ 2,131 | $ 52,924 | 0.4% |
| Recur Depr Psych-Severe | $ 1,267,437 | 1,658 | 343 | $ 764 | $ 3,695 | 0.4% |
| Intestinal Adhes W Obstr | $ 1,222,729 | 778 | 97 | $ 1,572 | $ 12,605 | 0.3% |
| Sec Mal Neo Brain/Spine | $ 1,207,929 | 427 | 85 | $ 2,829 | $ 14,211 | 0.3% |
| Cellulitis Of Leg | $ 1,166,145 | 1,033 | 230 | $ 1,129 | $ 5,070 | 0.3% |
| React-Oth Vasc Dev/Graft | $ 1,029,703 | 634 | 81 | $ 1,624 | $ 12,712 | 0.3% |
| Acq Spondylolisthesis | $ 1,004,936 | 209 | 58 | $ 4,808 | $ 17,326 | 0.3% |
| Malig Neo Corpus Uteri | $ 936,316 | 351 | 101 | $ 2,668 | $ 9,270 | 0.3% |
| Food/Vomit Pneumonitis | $ 920,236 | 607 | 64 | $ 1,516 | $ 14,379 | 0.3% |
| Cholelith W Ac Cholecyst | $ 792,850 | 299 | 92 | $ 2,652 | $ 8,618 | 0.2% |
| Dsct Of Thoracic Aorta | $ 632,923 | 239 | 16 | $ 2,648 | $ 39,558 | 0.2% |
| Antineoplastic Chemo Enc | $ 460,325 | 285 | 42 | $ 1,615 | $ 10,960 | 0.1% |
| Other | $ 203,407,443 | 97,932 | 24,292 | $ 2,077 | $ 8,373 | 58.0% |
| Top 50 Diagnosis | $ 147,503,651 | 52,541 | 12,391 | $ 2,807 | $ 11,904 | 42.0% |
| **GRAND TOTAL** | **$ 350,911,094** | **150,473** | **36,683** | **$ 2,332** | **$ 9,566** | **100%** |

**Appendix – C12**
Hospital Provider Class – Outpatient
2007 Payments by Age: Overall Hospital Costs



# APPENDIX D



# APPENDIX E

## BCBSM Hospital Audit Activities

### 2006 – 2007

| Audit Activity | 2006 | 2007 |
|---|---|---|
| DRG Validation | | |
| Number of Hospitals | 94 | 99 |
| Cases Reviewed | 19,369 | 19,568 |
| Identified Savings | $13,643,715 | $14,168,760 |
| Cases Appealed | 2,050 | 2,025 |
| Recoveries to date | $11,429,616 | $11,121,578 |
| Catastrophic Claims | | |
| Cases Audited | 197 | 196 |
| Identified Savings | $4,416,502 | $5,417,733 |
| Cases Appealed | 656 | 693 |
| Finalized Savings | $3,524,478 | $3,861,617 |
| Readmission Audits | | |
| Number of Audits | 59 | 67 |
| Identified Savings | $2,647,943 | $5,679,593 |
| Cases Appealed | 48 | 57 |
| Finalized Savings | $3,287,670 | $4,160,430 |
| Focus Compliance Audits | | |
| Number of Hospitals | 29 | Discontinued |
| Cases Reviewed | 1,724 | |
| Identified Savings | $1,656,136 | |
| Cases Appealed | 34 | |
| Peer Group 5 | | |
| Number of Hospitals | 4 | 32 |
| Cases Reviewed | 58 | 863 |
| Identified Savings | $1,656,134 | $279,961 |
| Cases Appealed | 34 | 291 |
| Transfer Audits | | |
| Number of Hospitals | 53 | 69 |
| Cases Reviewed | 143 | 155 |
| Savings | $661,798 | $504,805 |
| Hospital Outpatient Audits | | |
| Number of Audits | 97 | 44 |
| Identified Savings | $9,341,978 | $1,914,028 |
| Recoveries | $4,271,470 | $8,226 |
| Number of Appeals | 67 | 49 |

# APPENDIX F
## BCBSM Pay for Performance
## Collaborative Quality Initiatives

**BCBSM Cardiovascular Consortium Angioplasty Project**

The Cardiovascular Consortium is a hospital partnership spearheaded by BCBSM and the University of Michigan. The Cardiovascular Consortium Angioplasty Continuous Quality Improvement Project developed a clinical registry used to assess risk and monitor quality improvement for patients undergoing heart procedures like balloon angioplasty and stenting. Unlike previous assessment tools, the registry included a patient's individual medical history and provided physicians the resources they needed to rigorously examine angioplasty practice, to better define optimal care, and to use what is learned to improve patient outcomes.

The project resulted in safer and improved care for angioplasty patients across the state, saving lives, avoiding serious complications and saving $8 million per year on care provided to patients treated at the 16 partner hospitals. Results include higher usage of medicines that prevent complications, use of more appropriate amounts of dye, and less heparin use. In addition, there are now fewer complications like kidney failure and heart attacks.

**Thoracic and Cardiac Surgery Collaborative Quality Initiative**

This project aims to reduce the risk of complications and improve treatment methods before and after cardiac surgery for thousands of Michigan patients. This collaboration with the Michigan Society of Thoracic and Cardiovascular Surgeons will:

- Enable greater in-depth analysis of patient data
- Help coordinate best practices among surgeons in all 31 hospitals in Michigan that offer cardiac surgery
- Engage surgeons in an effort to delve more deeply than ever before into cardiac surgery outcomes and to take what is learned and apply it to better patient care statewide

The project builds upon data already compiled in the Society of Thoracic Surgeon national database. There are about 20,000 adult cardiac operations in Michigan annually.

**Michigan Bariatric Surgery Collaborative**

This partnership with physicians and hospitals is designed to make weight-reducing bariatric surgery safer and potentially less costly across the state.

All Michigan hospitals performing bariatric surgery are invited to share information on procedures and outcomes in a data registry. The data are be used to help determine which practices produce the least risk, fewest complications and the best results while, at the same time, help reduce costs for these increasingly common and expensive procedures. Currently there appears to be wide variation in the ways this surgery is performed and how pre- and post-operative care is structured.

**Michigan Surgical Quality Collaborative**

Sixteen of the largest hospitals in Michigan are participating in an initiative that evaluates the results of general and vascular surgery procedures performed in their institutions.

It is a pioneering effort between the American College of Surgeons and a BCBSM to evaluate and improve the quality of surgical care while ultimately reducing health care delivery costs.

Data on the outcome of surgeries is being submitted to the American College of Surgeons' National Surgery Quality Improvement Program. The goal is to use the data to reduce infection, illness or death associated with selected surgical procedures.

**Michigan Breast Oncology Quality Initiative**

In 2006 BCBSM is expanding a pilot program to improve the quality of care for the more than 7,000 Michigan women diagnosed with breast cancer each year.

The program expansion will increase the number of Michigan hospitals participating in the initiative. Working with researchers at the University of Michigan Health System, the Michigan Blues invited five new hospitals to participate in 2006. That number grew to 17 in 2007.

The initiative is contributing comprehensive data on diagnostic testing, chemotherapy, radiation therapy and surgery to a registry established by the National Comprehensive Cancer Network. It will help physicians learn what works best in breast cancer treatment.

**MHA Keystone Project on Hospital Associated Infections**

This initiative, introduced in 2006, is a BCBSM partnership with the Michigan Hospital Association and Michigan hospitals to reduce inpatient infection rates in general medicine and surgical wards. The project involves the collection and analysis of specific data from participating hospitals to provide feedback and develop solutions to reduce hospital-acquired infections. The goals of this program are to improve patient outcomes and reduce hospital costs as a result of lower infection rates.

# APPENDIX G

## Participating Hospital Agreement (PHA) Committees
## Major Discussion Topics
## 2006 – 2007

| Committee Name | 2006 Meetings | 2007 Meetings | Topics Discussed |
|---|---|---|---|
| PHA Committee | 4 | 3 | PHA revisions and approval<br>Hospital Pay-for-Performance Program<br>Outpatient Market-based Reimbursement<br>Peer Group 5 Reimbursement |
| Staff Liaison Group | 6 | 5 | The Staff liaison Group discusses and determines what will be placed on the PHA Advisory Committee agenda.<br>UMQA Committee issues<br>Outpatient Market-based Reimbursement Policy<br>Pay-for-Performance<br>Peer Group 5 Reimbursement<br>Outpatient Carve-out |
| Benefit Administration Committee | 6 | 5 | Elimination of Paper Claims<br>BlueCard<br>web-DENIS<br>Medicare Advantage<br>Over/Under Log<br>Physical Therapy Billing<br>Dual Coverage During Admission Policy<br>Radiology Management Program<br>NPI Project<br>CQI Initiatives<br>The committee has an Administration Simplification Issues Log and Accomplishments Log |
| Payment Practices Committee | 8 | 8 | Grouper Recalibration<br>Mom and Well-Baby DRG<br>Nonemergent Defibrillation<br>New Medicare Severity DRG Grouper<br>2008 Update Factor<br>Misclassification of Office and Hospital Surgeries on Front Sheets<br>Hospital Efficiency Incentive Scores<br>Defibrillator Case Payments<br>BCBSM Vouchers and Checks for NASCO 65 attestations<br>Nuclear stress test radiopharmaceutical (A9502)<br>Emergency Room Claims |

| Committee Name | 2006 Meetings | 2007 Meetings | Topics Discussed |
|---|---|---|---|
| Utilization Management & Quality Assessment Committee | 9 | 8 | ♦ Case Management<br>♦ Precertification<br>♦ InterQual Criteria<br>♦ Long-term Acute Care Hospitals<br>♦ Collaborative Quality Initiatives<br>♦ Pay-for-Performance<br>♦ BCBSM and Hospital Communications<br>♦ Inpatient vs. Outpatient Definitions<br>♦ Durable Medical Equipment<br>♦ Hospital Radiology Management<br>♦ Defibrillator Implants |

# Participation Agreements (Attached)

Participating Hospital Agreement

Participating Hospital Agreement – 2007 Incentive Program

Participating Hospital Agreement – 2006 Incentive Program


# SECOND AMENDED AND RESTATED PARTICIPATING HOSPITAL AGREEMENT

Revised – July 1, 2007

This Agreement is proprietary and confidential. Exhibit B of this Agreement can be released to Hospital's agents, contractors or consultants only if these parties sign a statement agreeing not to disclose the Agreement to third parties. Hospital cannot disclose Exhibit B to any other third parties without the prior written consent of BCBSM.

## Master Index

This Agreement is proprietary and confidential. Exhibit B of this Agreement can be released to Hospital's agents, contractors or consultants only if these parties sign a statement agreeing not to disclose the Agreement to third parties. Hospital cannot disclose Exhibit B to any other third parties without the prior written consent of BCBSM.


# Second Amended and Restated Participating Hospital Agreement

This Second Amended and Restated Agreement, by and between **Blue Cross Blue Shield of Michigan,** a Michigan nonprofit health care corporation, incorporated pursuant to Michigan Public Act 350 of 1980 as amended (hereinafter referred to as "BCBSM") and **Hospital,** whose tax name and site address is listed on the accompanying Signature Document (hereinafter referred to as "Hospital"), collectively known as the "Parties", **is effective on the later of July 1, 2007 or the effective date indicated on the attached Signature Document.**

## PREAMBLE

WHEREAS, BCBSM and Hospital have a mutual concern for high quality of care and recognize as a mutual objective the delivery of services by Hospital, to persons entitled to such services as defined herein, and reimbursement therefore by BCBSM, in a manner that promotes the continuation and improvement of an efficient, effective and consumer responsive health care delivery system; and,

WHEREAS, to achieve this mutual objective, the Parties enter into this Agreement with the following understanding of principles:

A. That each of the Parties has the legal authority to enter into this Agreement and that any other agreements by either Party with any other person or entity will in no way affect the rights or obligations embodied in this Agreement except as may be expressly provided in this Agreement;

B. That BCBSM accepts financial responsibility for the provision of Covered Services to its Members by Hospital and Hospital accepts responsibility for providing such services within the limitation of Hospital's scope of services, looking only to BCBSM for reimbursement, except as otherwise provided in this Agreement;

C. That each of the Parties is committed to the delivery of health care services in an efficient and effective manner, recognizing the need to control and contain cost, and recognizing Hospital's obligation to maintain and improve hospital care;

D. That each of the Parties recognizes that Hospital's governing body has ultimate authority and responsibility for Hospital's operation and a concurrent responsibility to the public in the delivery of health care;

E. That each of the Parties acknowledges its responsibility to the public it serves and its duty to exercise its rights and obligations under this Agreement in accordance with that responsibility; and

F. That BCBSM's social mission requires it to deliver health care services at a fair and reasonable price to all people of the state of Michigan who apply for coverage, and as a result, BCBSM's payment rates should be at least as favorable as those of commercial HMO and PPO payers.

NOW, THEREFORE in consideration of the mutual promises and covenants herein contained, the Parties agree as follows:

## Article I
Definitions

1. Audits - the audits set forth in this Agreement and in the Reimbursement Policies.

2. Certificate - benefit plan descriptions under the sponsorship of BCBSM, or certificates and riders issued by BCBSM, or under its sponsorship, or benefits provided pursuant to contracts issued by other Blue Cross or Blue Shield Plans, administered through reciprocity of benefit agreements or other Inter-Plan Arrangements. "Certificate" does not include benefits provided pursuant to automobile no fault or worker's compensation insurance coverage.

   For purposes of this definition, "sponsorship" includes:

   a. Self-funded administrative service accounts of BCBSM for which BCBSM (i) assumes the risk of reimbursing Hospital for Covered Services in the event the payer becomes insolvent and (ii) provides one or more of the following administrative services: utilization management, quality assessments, reviews, audits, claims processing systems or a cash flow methodology.

   b. Self-funded administrative service accounts for which another Blue Cross or Blue Shield Plan is Control Plan and BCBSM is a participating plan and for which BCBSM or the Control Plan assumes the risk of reimbursing Hospital for Covered Services in the event the payer becomes insolvent.

   For purposes of this definition, "sponsorship" does not include health maintenance organizations ("HMO"), preferred provider organizations/point of service ("PPO/POS") benefit designs offered by BCBSM or its subsidiaries, or by other BCBS Plans or their subsidiaries.

3. Clean Claim - a claim submitted in the correct electronic format or on the correct claim form that includes all of the following information:

   a. The name of the Hospital and appropriate provider number;

   b. The name of the Member and the contract number;

   c. Date and location of service;

   d. Description of Covered Services rendered;

e. If requested, substantiation of medical necessity and appropriateness of the care or service provided; and

f. Any additional documentation that may be reasonably requested by BCBSM.

4. Contract Administration Process ("CAP") - the process set forth in Article IV, Sections 1 through 11 of this Agreement.

5. Covered Services - those hospital services, treatments or supplies which are listed or provided for as being covered in Certificates.

6. Customer-Specific Programs - those programs applicable to one or a limited number of BCBSM customers.

7. Experimental Services - those services excluded from payment under BCBSM's Certificates.

8. Medical Necessity or Medically Necessary - a determination that a Covered Service meets all of the following conditions: (i) it is rendered for the treatment, diagnosis or symptoms of an injury, condition or disease; (ii) the care, treatment or supply is appropriate given the symptoms, and is consistent with the diagnosis. "Appropriate" means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment. For inpatient hospital stays, this means that acute care as an inpatient is necessary due to the kind of service the Member requires and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting; (iii) it is not mainly for the convenience of the Member or of the Member's health care provider; (iv) it is not treatment that is generally regarded as experimental by BCBSM, except as otherwise provided in a Certificate and (v) it is not determined to be medically inappropriate by the Utilization, Quality and Health Management Programs.

9. Member - a person entitled to receive Covered Services pursuant to a Certificate.

10. Non-Covered Services - those hospital services, treatments or supplies which are not Covered Services.

11. Non-Reimbursable Covered Services - those Covered Services for which BCBSM will not make payment because the Covered Services are: (i) not Medically Necessary as determined through Utilization, Quality and Health Management Programs, except for those situations referenced in Article III, Section 8; (ii) provided in certain facilities other than those approved by BCBSM.

12. Overpayment - any payment in excess of the amount to which Hospital is entitled under this Agreement.

13. Participating Hospital - any hospital having a contract with BCBSM that is substantially similar to this Agreement.

14. Peer Group - a grouping of hospitals that share similar characteristics such as bed capacity, location, graduate teaching characteristics and specialty type as provided in the Reimbursement Policies.

15. Precertification - a review of a patient's signs, symptoms and proposed treatment to determine whether they meet BCBSM criteria for clinical appropriateness and/or level of care.

16. Prenotification - a process established by BCBSM under which Hospital will report to BCBSM certain information regarding the patient and proposed services.

17. Qualification Standards - those criteria which are used to determine Hospital's eligibility to become or remain a Participating Hospital as set forth in Exhibit A, attached hereto and incorporated herein.

18. Recertification - a prospective review to determine whether admissions continue to be appropriate for the inpatient setting.

19. Reimbursement Policies - the policies which determine the amount of payment due Hospital by BCBSM for Covered Services, as set forth in this Agreement, Exhibit B, attached hereto and incorporated herein, and in the Provider Reimbursement Manual and additional BCBSM published guidelines and criteria.

20. Reviews - the medical and billing reviews set forth in this Agreement and in the Utilization, Quality and Health Management Programs.

21. Non-Network Hospital - any Participating Hospital that has not signed a TRUST Participating Hospital Agreement or other BCBSM hospital network agreements.

22. Underpayment - any payment less than the amount to which Hospital is entitled under this Agreement.

23. Utilization, Quality and Health Management Programs - the Utilization, Quality and Health Management Programs set forth in Exhibit C, and in BCBSM published guidelines, criteria and administrative manuals.

## Article II
Hospital Responsibilities

1. General Responsibility of Hospital to Members. Hospital will provide Covered Services to Members which are ordered by a licensed physician or other health care professional in the same manner and quality within the same time frames as those services provided to all other Hospital patients. Hospital shall not be required to provide any Covered Services that it does not customarily provide to others. Hospital will not deny admission or fail to provide Covered Services to any Member by virtue of the Member's BCBS coverage or discriminate against a Member because of his or her status as a Member.

2. Limited Responsibility of a Non-Network Hospital. A Non-Network Hospital, within the limitations of its scope of services, shall provide services to Members in exchange for payment by BCBSM as follows:

   a. For Members that utilize the TRUST hospital network or another hospital network open to all hospitals throughout the State that meet the applicable network qualification standards, BCBSM shall pay Hospital the lower of

(i) charges for Covered Services or (ii) Hospital's applicable rate under the PHA.

b. For Members in PPO/POS benefit designs that utilize PPO/POS hospital networks not open to all qualified hospitals throughout the State or PPO/POS hospital networks for one or a limited number of BCBSM customers, BCBSM shall pay Hospital the lower of (i) charges for Covered Services; or (ii) 115 percent of the Hospital's applicable rate under the PHA.

3. Hospital Qualifications and Covered Services within Scope of License. Hospital shall have and maintain all the Qualification Standards in Exhibit A and shall comply with BCBSM's recredentialing requirements.

Only those Covered Services provided within the scope of Hospital's license shall be governed by the terms and conditions of this Agreement. Covered Services that are provided outside of the scope of Hospital's license are outside of the scope of this Agreement and shall be subject to a separate agreement with BCBSM pursuant to BCBSM's applicable freestanding facility programs.

4. Scope of Responsibility. The terms of any participating hospital agreement in effect between BCBSM and Hospital on the date a Member's inpatient admission or outpatient service occurs shall govern Hospital's obligations to provide Covered Services to Members. Terms of any participating hospital agreement in effect at the time of admission shall govern for the balance of an inpatient admission.

5. Eligibility, Coverage and Benefit Verification; Prenotification. Hospital shall verify current status of Member eligibility, coverage and benefits for all inpatient admissions for Covered Services and for certain outpatient Covered Services as may be reasonably identified by BCBSM at the time of admission. If Hospital verifies eligibility but BCBSM later determines that the individual was not eligible for coverage, Hospital may directly bill the member for such services. Hospital shall provide Prenotification when required by BCBSM and such other information as BCBSM may reasonably request to help manage patient care.

6. BCBSM Payment. Hospital shall look only to BCBSM for reimbursement for Covered Services in accordance with the Reimbursement Policies, except as otherwise provided in this Agreement.

7. Hold Harmless. Hospital shall not bill or collect from a Member for Covered Services or Non-Reimbursable Covered Services, except that Hospital may bill or collect from a Member for any one or more of the following:

a. Amounts attributable to Non-Covered Services, excluding Experimental Services;

b. Copayments and deductibles or amounts in excess of any yearly or lifetime maximum applicable to Covered Services as specified in applicable Certificates. Hospital will not waive copayments, deductibles or amounts in excess of any yearly or lifetime maximum that are the responsibility of the Member, except for hardship cases that are documented in the Member's record, or where reasonable efforts to collect have failed;

c. Amounts attributable to Non-Reimbursable Covered Services or Experimental Services in those limited situations where the Member specifically agrees in writing in advance of receiving such services to the following: (i) the Member acknowledges that BCBSM will not make payment for such services, (ii) the Member consents to receipt of such services, and (iii) the Member assumes financial responsibility for such services;

d. Amounts attributable to Non-Reimbursable Covered Services in those limited situations where a Member who is a Hospital inpatient refuses to leave the Hospital following a documented determination by the Member's physician that acute care services are no longer necessary, regardless of whether the Member assumes financial responsibility for such services in writing in advance of the receipt of such services;

e. Amounts attributable to Covered Services where Hospital, despite its best efforts to determine whether an individual is a Member, is not informed that an individual is a Member; or

f. Amounts attributable to Covered Services if all of the following requirements are met: (i) Hospital documents that a bill was not submitted to BCBSM within twelve (12) months because a Member failed to provide proper identifying information, (ii) Hospital submits the bill to BCBSM for payment consideration within three (3) months after obtaining the necessary information, and (iii) BCBSM does not authorize payment by reason of the late submission.

Except for Non-Covered Services, Experimental Services and those Covered Services and Non-Reimbursable Covered Services enumerated above, Hospital shall not require deposits from Members. For Non-Covered Services, Experimental Services and those Covered Services and Non-Reimbursable Covered Services enumerated above, Hospital may require a reasonable deposit.

8. Claims Submission. Hospital shall submit claims for Covered Services to BCBSM using standard, electronic formats and codes as approved through National and State Uniform Billing Committees.

a. Claims shall comply with the requirements as stated in published BCBSM administrative manuals or additional published guidelines or criteria.

b. Hospital shall submit Clean Claims for Covered Services promptly after discharge or transfer of the Member or date of an outpatient service. The terms "discharge" and "transfer" apply to Hospital inpatient Covered Services. Original claims and modifications to that claim for Covered Services shall be billed within twelve (12) months after the date of discharge, transfer or service.

c. Notwithstanding the foregoing, after the expiration of the 12-month claim submission period, a Hospital claim may be initially billed to BCBSM within three (3) months after any one or more of the following has occurred:

i. Hospital obtains the necessary information to bill BCBSM and documents that a bill was not submitted within the applicable claim submission period because Hospital reasonably believed that BCBSM was secondary to another payer; or

ii. Hospital obtains the necessary information and documents that a Member failed to provide proper identifying information after an appropriate request was made prior to expiration of the effective claim submission period; or

iii. BCBSM is the secondary payer.

9. Coordination of Benefits and Other Party Liability. Hospital shall cooperate with BCBSM regarding coordination of benefits. Hospital procedures shall include admission and billing practices which ask Members for duplicate coverage or information necessary to determine coordination of benefits.

Hospital shall notify BCBSM of any and all known duplicate coverage obtained from such procedures by so indicating in the claims submission process.

a. If Hospital knows that another party is primary and BCBSM is secondary, Hospital shall first bill that party and shall notify BCBSM of all inpatient Covered Services for which that party assumed primary liability under a claims reporting procedure to be established by BCBSM, with any secondary BCBSM payment liability to be paid to Hospital by BCBSM.

b. In all other situations, Hospital shall first bill BCBSM, with BCBSM payment to Hospital to be made subject to Article III, Section 7.

10. Recordkeeping Requirements. Hospital shall prepare and maintain all appropriate medical and financial records related to Covered Services to Members and as required by law.

11. Notification and Escrow Requirements. Hospital shall comply with the following requirements:

a. Notification. Hospital shall notify BCBSM thirty (30) days in advance of the effective date of the following:

i. Changes in ownership or corporate structure, including the nature of the transaction and names of successor owners;

ii. The filing of a petition for relief under the U.S. Bankruptcy Code, appointment of a trustee, receiver or any action taken to dissolve, liquidate, terminate, consolidate, merge or sell all or substantially all of Hospital's assets;

iii. A twenty (20) percent or more reduction in the number of admissions or outpatient services in any six (6) month period;

b. Reporting. Each year Hospital shall fully complete and send to BCBSM the Medicare Cost Report, the BCBSM cost report, Audited Financial Statements and any other supporting documentation that may be reasonably requested by BCBSM.

c. Transfer of Hospital Assets. Hospital shall give BCBSM written notice as early as possible before Hospital transfers all or substantially all of its assets if the acquiring entity does not expressly assume Hospital's liabilities to BCBSM, or the acquiring entity is neither (1) a Participating Hospital nor (2) a Hospital commonly controlled legal entity, such as a parent or sister corporation or entity. Hospital and BCBSM shall agree upon an amount that shall be escrowed from the proceeds of such transfer to cover any outstanding liability to BCBSM.

12. Overpayments. Hospital shall promptly report and refund to BCBSM through a process identified by BCBSM any Overpayment under this Agreement discovered by Hospital. In lieu of a refund, Hospital may request BCBSM to offset the overpayment against future payments due Hospital under this Agreement

13. Access to Records.

a. Filing Requirements.

i. Hospital shall provide BCBSM with a cost report and an electronic version of its submitted Medicare Cost Report within one hundred eighty (180) days after the end of its fiscal year or at the time the Medicare Cost Report is submitted, whichever is later. A copy of the signed Medicare Cost Report signature page shall be provided.

ii. Hospital shall provide a complete set of audited Hospital and corporate financial statements, if available, at the same time as the Medicare Cost Report is submitted.

iii. Hospital shall provide BCBSM access to other financial reports and information as needed to administer this Agreement. These include but are not limited to Hospital charge master, adjusted trial balance, trial balance roll-up schedules and intern and resident schedules.

iv. Failure to comply with any of the above requirements will result in an immediate halt to all cash payments to Hospital pursuant to this Agreement. Cash payments will immediately resume when Hospital complies with the above requirements.

b. Coding and Documentation.

i. BCBSM shall establish acceptable performance levels related to hospital outpatient coding and documentation. Recovery shall be made for all cases where coding and documentation errors are found. The error results and recovery shall not be extrapolated. Coding errors shall be aggregated to determine the net amount to be recovered by BCBSM or refunded to Hospital.

ii. BCBSM shall establish a process that validates the accuracy of DRG coding by hospitals. This DRG validation process shall utilize nationally accepted coding guidelines. Coding errors shall be aggregated to determine the net amount to be recovered by

BCBSM or refunded to Hospital (recovery shall not be based on extrapolation).

iii. All other audits conducted by BCBSM, including but not limited to audits of readmissions and non-acute cases, shall utilize nationally accepted guidelines (and shall be subject to recovery on a case-by-case basis and not based on extrapolation).

c. Compliance Penalties. Under the following circumstances, BCBSM shall be authorized to recover amounts equal to three times the identified Overpayments. BCBSM shall not impose treble damages based on the amount of extrapolated Overpayments. For this provision to apply, all of the following conditions must be met:

i. The Overpayment must be identified through an audit described in Article II, Section 13.b.i. 13.b.ii. or 13.b.iii. above, or result from an error on a financial statement or report submitted to BCBSM.

ii. BCBSM shall have determined that there is a pattern or practice of errors by Hospital resulting in Overpayments that is persistent and recurrent in nature, and BCBSM shall have notified Hospital in writing that Hospital will be subject to treble damages if, following a reasonable period of time to take corrective action, the pattern or practice is not corrected. Treble damages shall not apply with respect to Overpayments which arise out of Hospital actions taken before notice and expiration of a reasonable amount of time to take corrective action.

iii. The Overpayment does not arise out of a legitimate dispute between Hospital and BCBSM.

iv. The decision to impose the treble damage penalty is reviewed and approved by the Internal Review Committee.

## Article III
BCBSM Responsibilities

1. General Responsibility. BCBSM shall have the following obligations and such other obligations as are established by or pursuant to this Agreement.

2. Scope of Responsibility. BCBSM's payment obligations under this Agreement will be governed by the Reimbursement Policies and in the same manner as Hospital's scope of responsibility as provided in Article II, Section 4. The discounts under this Agreement shall apply only to services provided to a Member issued a BCBS identification card.

3. Member Identification. BCBSM shall provide identification cards to Members. BCBSM shall provide Members, at the time of enrollment and in advance of each relevant change in procedures, coverage and obligations subsequent to enrollment, with written information necessary to accurately and adequately inform Members of the procedures for obtaining Covered Services from Hospital and of their obligations to Hospital with respect to copayments, deductibles and Non-Covered Services, among other matters.

4. Eligibility, Coverage and Benefit Verification; Prenotification. Hospital shall be provided with a system and/or method for verification of eligibility, coverage and benefits (including information on copayments and deductibles), and for Prenotification. The system and/or method shall be accessible to Hospital on a 24-hour, 7-day-per-week basis, except during periods of routine maintenance. Eligibility, coverage and benefit verification information shall be provided as a service and not as a guarantee of payment.

5. Claims Processing. Claims shall be processed and paid by BCBSM to Hospital in forty five (45) days in accordance with the terms of this Agreement.

6. Coordination of Benefits and Other Party Liability. As provided in Article II, Section 9 (b), where Hospital does not know that another party is primary and Hospital first bills BCBSM, one of the following shall occur:

   a. For BCBSM customers that have a Pay and Pursue coordination of benefits program in which coordination of benefits activities are performed on a post-payment basis, BCBSM shall accept the claim, process the claim and pay Hospital in accordance with the Reimbursement Policies.

   b. For BCBSM and BCBSM customers that have a Pursue and Pay coordination of benefits program in which coordination of benefit activities are performed on a pre-payment basis, BCBSM shall accept the claim and process the claim by pending the claim. During the time the claim is pended, BCBSM shall investigate coordination of benefits obligations. After the claim has been accepted, pended and investigated by BCBSM, BCBSM shall pay the claim in accordance with this Agreement and the Reimbursement Policies if BCBSM is primary and reject the claim if another party is primary. When a claim is submitted, pended and investigated, BCBSM shall apply its payment rule policy to determine primary and secondary liability, as the same may change from time to time, in a coordination of benefits situation in which both the "birthday" rule and the "gender" rule are in effect.

   In those situations where BCBSM is secondary, BCBSM shall reimburse Hospital for its secondary balance in accordance with this Article III, Sections 7 and 8 and the Reimbursement Policies.

7. BCBSM Payment for Covered Services to Members. BCBSM shall make direct payments to Hospital for Covered Services provided to Members in accordance with the Reimbursement Policies.

   a. BCBSM shall not pay Hospital in the following situations:

      i. Where Non-Covered Services are provided to Members;

      ii. Where Non-Reimbursable Covered Services are provided to Members, except as provided in this Article III, Section 8.

   b. Where (i) coordination of benefits and other party liabilities are applicable and (ii) BCBSM is secondary, BCBSM shall pay Hospital at the lesser of BCBSM's approved amount for Covered Services net of the other party's

payment and the Member's copayments and deductibles or the amount submitted by Hospital as its secondary balance. However, in no event shall BCBSM payment exceed the amount payable under Reimbursement Policies. Where there are two separate contracts involved which are both with BCBSM, BCBSM shall pay Hospital in accordance with Reimbursement Policies.

c. BCBSM shall make weekly prospectively determined interim payments ("BIP") to Hospital. In the event that BIP payment dates fall on a holiday or weekend, such payment will be made on the next business day. BIP payments are subject to determination, adjustment and reconciliation in accordance with Reimbursement Policies and to BCBSM's right of recovery as provided in Article VI.

d. If BCBSM is temporarily unable to meet its financial obligations arising out of this Agreement, such obligations shall be construed as a continuing liability to Hospital to be satisfied within a reasonable time, subject to Hospital's rights of termination pursuant to Article V, Section 2. This section shall not be construed to limit or remove any rights that Hospital may have with respect to late BCBSM payments as a matter of law.

e. Where an inpatient admission is a high-cost catastrophic case, as defined in the Reimbursement Policies, and the inpatient admission was appropriate because acute care as an inpatient was necessary due to the kind of care the Member required and safe and adequate care could not be received as an outpatient or in a less intensified medical setting but certain services received during the course of the inpatient admission were not Medically Necessary, BCBSM will pay Hospital in accordance with the Reimbursement Policies but BCBSM may reduce Hospital's high-cost catastrophic case payment by the amount of the services determined to be not Medically Necessary.

8. BCBSM Payment for Non-Reimbursable Covered Services. BCBSM shall pay Hospital for Non-Reimbursable Covered Services in the following limited situations:

a. Where Precertification determined appropriateness of inpatient level of care, BCBSM shall pay for the inpatient admission in accordance with the Reimbursement Policies, even if upon retrospective Review, BCBSM determines that an inpatient level of care was not required, so long as Covered Services met all other components of the Medical Necessity determination, inpatient intensity of service was delivered, and if applicable, the documentation in the medical record is consistent with the notes from the Precertification approval.

b. Where Precertification was not performed and any retrospective Review conducted pursuant to Exhibit C subsequently determines that the Covered Services met all components of the Medical Necessity determination except that an inpatient level of care was not required, BCBSM will pay for Covered Services at the appropriate outpatient rate in accordance with the Reimbursement Policies.

9. Participating Hospital Lists, Directories or Other Information. BCBSM shall include Hospital's name and other appropriate identifying information in any lists,

directories or other information provided to Members or third parties for so long as Hospital is a Participating Hospital. BCBSM shall not include Hospital's name or other identifying information in any lists, directories or other information provided to third parties which might reasonably be construed to suggest that Hospital is a member of a network of hospitals of an HMO, PPO or POS owned or controlled in whole or in part by BCBSM or one of its subsidiaries unless Hospital has also signed a separate agreement with BCBSM to participate in such network.

10. Administrative Manuals and Bulletins. BCBSM shall at no charge provide Hospital with one hard copy of or, when available, electronic access to all current and historical administrative manuals, bulletins, and such other documents and information as may be reasonably necessary for Hospital to effectively and efficiently furnish Covered Services to Members and be paid therefore. BCBSM shall also provide Hospital with Certificates upon request.

11. Customer-Specific Programs. At the request of a customer, BCBSM will establish and administer Customer-Specific Programs. BCBSM will use its best efforts to make Customer-Specific Programs uniform and standardized. The following provisions will apply with respect to Customer-Specific Programs:

a. Unless otherwise agreed to by Hospital, if a Customer-Specific Program provides that one or more services (except mental health and substance abuse) otherwise subject to reimbursement under this Agreement will be reimbursed under a different agreement, then this Agreement will not apply to any other services Hospital provides to the customer's members.

b. This Agreement will apply to services provided by Hospital to Members enrolled in Customer-Specific Programs that use an entity other than BCBSM or its subcontractor to administer a component of the PHA involving Precertification, Recertification, Prenotification, Retrospective Utilization Review or claims processing. If participation in such a program will involve substantial administrative burden, BCBSM will implement an industry-wide payment increase on a customer-specific basis to compensate hospitals for the additional costs and/or complexity involved in complying with the program as determined through the CAP.

c. Hospital will participate in all reasonable Customer-Specific Programs that involve Audits and Reviews to ensure the accuracy of payments under this Agreement. Customer-specific Audits and Reviews may involve customer-selected contractors. In such cases, BCBSM will coordinate the interface between the contractor and Hospital. BCBSM will work with customers to ensure any customer-specific Audits and Reviews do not duplicate existing BCBSM Audits and Reviews.

12. Advertising and Publication. BCBSM may advertise and publicize the names of Participating Hospitals.

## Article IV
Contract Administration Process

1. Establishment. BCBSM hereby establishes an ongoing Contract Administration Process ("CAP") through which Hospital and other Participating Hospitals may provide non-binding input and recommendations to BCBSM with respect to all decisions, matters and activities within the jurisdiction of the CAP, to the extent allowed by law. BCBSM commits to give significant consideration to input from the CAP.

2. Amendments to the Agreement. This Agreement may be amended by BCBSM and Hospital as set forth in Article V, Section 5. In addition, if the BCBSM board of directors approves, as presented, a recommendation of the PHA Advisory Committee to amend this Agreement, it shall become a binding part of this Agreement after not less than thirty (30) days written notice to Hospital. Additional notice may, at BCBSM's option, be published in an appropriate BCBSM provider publication (e.g. *The Record or* web-DENIS).

3. Applicability of the Contract Administration Process.

   a. The CAP applies to all existing and future BCBSM standard and Customer-Specific Programs affecting Hospital services under this Agreement.

   b. Any action which BCBSM takes with respect to the following matters must be mutually agreed upon by BCBSM and Hospital. Alternatively, action by BCBSM with respect to any of the following matters shall be binding on the Hospital if such action is consistent with the non-binding input and recommendations of the appropriate CAP committee:

      i. Pay-for Performance programs oversight;

      ii. Utilization, Quality and Health Management Programs, including without limitation standards, reporting guidelines, medical record reviews and interventions;

      iii. Centers of Excellence requirements;

      iv. Reimbursement Policies;

      v. Notification requirements;

      vi. Reviews and Audits, including the payment to be made by BCBSM for copies of medical and billing records;

      vii. Methods of payment;

      viii. Claims reporting;

ix. Financial Reporting requirements for hospitals;

x. Billing procedures;

xi. Claims processing;

xii. Systems and/or methods for verification of eligibility, coverage and benefits;

xiii. Prenotification, Precertification and Recertification;

xiv. Qualification standards;

xv. Determination of the reasonableness of Customer-Specific Programs under Article III Section 11;

xvi. Compliance with performance, reporting and billing standards, and acceptable performance levels for coding and documentation for purposes, among others, of imposition of treble damages on Hospital;

xvii. Appeals;

xviii. The adoption, rescission, implementation or modification by BCBSM of manuals, implementation schedules, criteria, guidelines, policies, standards and timeframes for Hospital action with respect to matters to which this Agreement applies; and

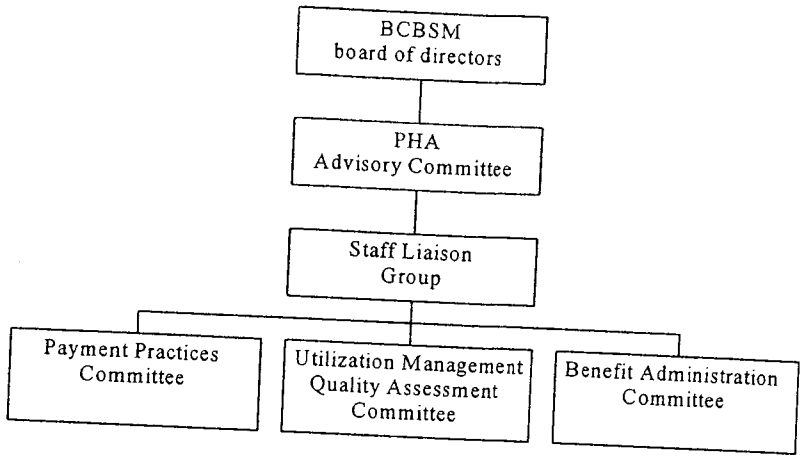
xix. Any other matters to which the CAP applies pursuant to the terms of this Agreement.

4. Non-Applicability of the Contract Administration Process. The CAP does not apply to changes in any BCBSM health care benefits and benefit structures.

5. Organization. The Contract Administration Process shall be organized through the following committees: (i) Participating Hospital Agreement ("PHA") Advisory Committee, (ii) Utilization Management and Quality Assessment Committee, (iii) Payment Practices Committee, (iv) Staff Liaison Group, (v) Benefit Administration Committee and (vi) such additional committees as may be established to report to or through these committees from time to time.

In addition to providing non-binding input and recommendations to BCBSM pursuant to the Contract Administration Process, certain committees, as may be approved by BCBSM from time to time, shall make recommendations to BCBSM with respect to appeal activities or such other activities as may be authorized by BCBSM from time to time.

The organization of the Contract Administration Process is graphically depicted as follows:




6. Participating Hospital Agreement ("PHA") Advisory Committee. A PHA Advisory Committee shall be established to provide non-binding input and recommendations regarding the implementation/administration and any modifications of the Participating Hospital Agreement, Exhibits and BCBSM administrative manuals as may be proposed from time to time. The PHA Advisory Committee shall have jurisdiction over all matters to which the Contract Administration Process applies. The PHA Advisory Committee shall, among other things:

a. Make non-binding recommendations regarding the coordination and review of actions of the Utilization Management and Quality Assessment and Payment Practices Committees;

b. Forward non-binding recommendations to the BCBSM board of directors on any matters relating to the Agreement or the relationship between BCBSM and Participating Hospitals;

c. Make non-binding recommendations regarding the resolution of differences that may arise in the Benefit Administration, Utilization Management and Quality Assessment and Payment Practices Committees;

d. Make non-binding recommendations to changes in Reimbursement Policies;

e. Discuss and make non-binding recommendations to BCBSM on public policy issues affecting health care delivery and proposed changes in BCBSM health care benefits and benefit structures;

f. Entertain appeals by Hospital or groups of hospitals on all matters within the scope of the Agreement, excluding those appeals covered under Exhibit D, in accordance with the appeal procedures set forth in BCBSM administrative manuals and make non-binding recommendations to the BCBSM board of directors with respect to such appeals;

g. Adopt and amend from time to time policies to address conflicts of interest that may arise when CAP committee representatives affiliated with hospitals that own PPOs or other managed care products are asked to consider issues related to BCBSM PPOs or other managed care products. The policies shall include provisions for disclosure of potential conflicts by committee members as well as provisions for abstention from discussions and providing input and recommendations on particular matters; and

h. Provide non-binding input and recommendations to further the relationship between BCBSM and Participating Hospitals.

The PHA Advisory Committee shall consist of equal numbers of persons appointed by BCBSM and the Michigan Health and Hospital Association ("MHA"). BCBSM appointees shall not include BCBSM staff and shall include at least one (1) public member of the BCBSM board of directors and at least one (1) small group or non-group member of the BCBSM board of directors. MHA appointees shall not include MHA staff and shall include at least one (1) member of the MHA corporate board. Staff from both BCBSM and MHA shall participate as invited guests.

The PHA Advisory Committee shall meet on an ad hoc basis at the request of either BCBSM, MHA, Hospital or group of hospitals exercising appeal rights in accordance with BCBSM appeal procedures.

7. Staff Liaison Group. A Staff Liaison Group shall be established consisting of the co-chairpersons of the Benefit Administration Committee, Utilization Management and Quality Assessment Committee and Payment Practices Committee. The Staff Liaison Group will meet as necessary to oversee and coordinate the activities of these three committees and to develop recommendations for and report to the PHA Advisory Committee. To the extent that each matter, action or activity to which the Contract Administration Process applies is relevant or reasonably related to more than one committee, it shall be under the jurisdiction of each relevant Committee and coordinated by the Staff Liaison Group before presentation to, and recommendation by, the PHA Advisory Committee.

8. Payment Practices Committee. A Payment Practices Committee shall be established consisting of equal numbers of persons appointed by BCBSM and MHA. The Payment Practices Committee shall be composed of BCBSM senior and mid-level management responsible for the activities within the jurisdiction of this Committee and MHA staff, augmented by representatives from Participating Hospitals with expertise in the activities within the jurisdiction of the Committee. All matters, actions and activities to which the Contract Administration Process applies which are relevant or reasonably related to payment practices shall be within the jurisdiction of this Committee. The Committee shall meet as necessary to discuss payment administration and policy issues.

9. Utilization Management and Quality Assessment Committee. A Utilization Management and Quality Assessment Committee shall be established consisting of equal numbers of persons appointed by BCBSM and MHA. The Utilization Management and Quality Assessment Committee shall be composed of BCBSM senior and mid-level management responsible for the activities within the

jurisdiction of this Committee and MHA staff, augmented by representatives from Participating Hospitals with expertise in the activities within the jurisdiction of the Committee. All matters, actions and activities to which the Contract Administration Process applies, which are relevant or reasonably related to utilization, quality and health management, shall be within the jurisdiction of this Committee. The Utilization Management and Quality Assessment Committee shall meet as necessary.

10. Benefit Administration Committee. The Benefit Administration Committee shall be established to provide input to BCBSM on administrative issues and to act in a joint manner to solve problems related to administrative issues. The Committee shall consist of administrative staff appointed by BCBSM and such Participating Hospital personnel and MHA staff appointed by MHA. The Benefit Administration Committee shall meet as necessary.

11. Special Work Groups and/or Task Forces. On occasion, issues which cut across the committees described above shall be reviewed through the Contract Administration Process. When deemed appropriate by either the Participating Hospital Agreement Advisory Committee or the Staff Liaison Group, special cross-jurisdictional work groups or task forces may be appointed to review such issues in place of, or in addition to, the standing committees. Non-binding recommendations for such groups shall be reported to the PHA Advisory Committee. Membership of such groups shall be appointed by the MHA and BCBSM, respectively.

## Article V
General Provisions

1. Term. This Amended and Restated Agreement shall commence as of the later of July 1, 2006 or the effective date indicated on the attached Signature Document and shall continue until terminated as provided below.

2. Termination.

   a. This Agreement may be terminated as follows:

      i. By either Party, upon one hundred twenty (120) days written notice of intent to terminate. Such termination may be with or without cause;

      ii. By either Party, as provided in this Article V, Section 6, below;

      iii. By Hospital, at its option, in the event that BCBSM is unable to meet its financial obligations as set forth in Article III, Section 7(d), for a period of at least fifteen (15) consecutive days and Hospital provides BCBSM with thirty (30) days advance written notice of termination;

iv. By either Party, if any voluntary or involuntary petition or similar pleading under any chapter of the United States Bankruptcy Code shall be filed by or against either Party, or any voluntary or involuntary proceedings in any court or tribunal shall be instituted to declare either party insolvent or unable to pay its debts, and in the case of the involuntary petition or proceedings, the petition or proceeding is not dismissed within sixty (60) days from the date it is filed, the other Party may terminate this Agreement upon written notice to Hospital or BCBSM, as the case may be, effective upon receipt of such notice;

v. By Hospital or by BCBSM, immediately in the event that Hospital ceases to do business or ceases providing Covered Services to Members;

vi. By BCBSM, immediately, if Hospital loses its licensure or Hospital fails to meet the Qualification Standards in Exhibit A, provided that the Agreement shall be terminated only with respect to that portion of Hospital facility not in compliance with licensure or Qualification Standards;

vii. By BCBSM, immediately, if Hospital is not allowed to participate in federal or state health care programs;

viii. By either party at any time, in the event of a breach of any material term, condition, warranty or representation of this Agreement that is not cured within 30 days of the detailed written notice of the cause of the breach.

b. In the event that this Agreement terminates for any reason, Hospital shall continue to furnish Covered Services to any Member who is a Hospital inpatient on the effective date of such termination until discharge or transfer from Hospital in accordance with Article II, Section 4, except for termination due to Hospital's loss of licensure. BCBSM shall pay Hospital for such inpatient Covered Services in accordance with the terms of this Agreement.

3. Assignment. Any assignment or delegation of rights or duties arising out of this Agreement by either Party without the prior written consent of the other Party shall be void. No assignment of Hospital's or BCBSM's rights and duties under this Agreement shall be approved unless assignee agrees to assume in writing all liabilities of the assignor under this Agreement.

4. Prior Agreements. This Agreement is the entire agreement between the parties regarding matters contained herein and supersedes any other discussion and agreements. However, this Agreement will have no effect on any Hospital-specific contract amendments that were entered into prior to and whose term extends past the effective date of this Agreement.

5. Amendments. This Agreement or any part or section of it may be amended at any time during the term of the Agreement by mutual consent in writing of the duly authorized representatives of BCBSM and Hospital.

6. Severability. In the event that any provision of this Agreement is rendered invalid or unenforceable by any state or federal law, rule or regulation or by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect. In the event that a provision of this Agreement is rendered invalid or unenforceable and its removal has the effect of materially changing the obligations of either party in such manner as, in the judgment of the Party affected, (i) will cause serious financial hardship to such Party, or (ii) cause such Party to act in violation of its corporate articles of incorporation or bylaws, the Party so affected shall have the right to terminate this Agreement upon thirty (30) days written notice to the other Party.

7. No Third Party Rights/Limited Enforcement. This Agreement is intended solely for the benefit of the Parties hereto, and there is no intention, express or otherwise, to create rights or interests for any Party or persons other than BCBSM and Hospital. This Agreement shall be enforceable only by the Parties hereto and no other person shall have the right to enforcement of the provisions contained herein, including without limitation, any BCBSM customer, Member or any other individual.

8. Waiver of Breach. Waiver of breach of any provision of this Agreement shall not be construed as a continuing waiver of such breach or a waiver of any other breach of the same or a different provision.

9. Entire Agreement. This Agreement, as it may be amended from time to time, together with any and all Exhibits, contains the entire Agreement between the Parties.

10. Non-Exclusivity. The Parties acknowledge that this Agreement does not in any manner limit either Party from entering into similar agreements with other parties.

11. Names, Symbols, Trademarks and Service Marks. The Parties each acknowledge the proprietary nature of and reserve the right to and the control of their respective names, symbols, trademarks and service marks now existing or later established. The Parties agree that neither shall use the other's name, symbols, trademarks and service marks, except as otherwise provided in this Agreement, without the prior written consent of that Party and shall cease any such impermissible usage immediately upon notice from the other Party or upon termination of this Agreement.

12. Section Headings. The section headings used herein have been inserted for convenience of reference only and shall not in any way modify or restrict any of the terms or provisions hereof.

13. Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Michigan. In the event of any unresolved dispute, jurisdiction will be in Michigan.

14. Notices. Any notice required or permitted under this Agreement shall be given in writing and sent to the other Party by hand-delivery, or postage prepaid regular mail at the following address or such other address as a Party may designate from time to time.

If to Hospital:

Hospital's name and address on
BCBSM provider file.

If to BCBSM:

Provider Contracting Department B715
Blue Cross Blue Shield of Michigan
600 East Lafayette Boulevard
Detroit, Michigan 48226-2998

15. Independent Contractor Clause. BCBSM and Hospital are independent entities. Nothing in this Agreement shall be construed as, or be determined to create, a relationship of employer and employee, or principal and agent, joint ventures, partners or any relationship other than that of independent parties contracting with each other solely for the purposes of carrying out the provisions of this Agreement.

16. BCBSA Status Disclosure Clause. This Agreement is between Hospital and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association (BCBSA) to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by accepting this Agreement, Hospital agrees that it made this Agreement based only on what it was told by BCBSM or its agents. Only BCBSM has an obligation to Hospital under this Agreement and no other obligations are created or implied by this language.

17. Compliance with Laws and Administrative Manuals. Both parties shall comply with all applicable laws and regulations. In addition, both parties shall comply with BCBSM administrative manuals as they may be developed, implemented and modified from time to time under the CAP. In addition, both parties will comply with BCBSM policies upon 60 days written notice. Such notice will be given by publication in either *The Record* or web-DENIS.

## Article VI
Reviews, Audits and Recoveries

1. Reviews and Audits. Subject to all applicable laws and the confidentiality provisions set forth in Article VII of this Agreement, Hospital shall allow BCBSM to conduct the following Reviews and Audits. Reviewers shall use their best efforts to minimize disruption to normal Hospital operations while conducting such Reviews and Audits.

a. Medical Record and Billing Reviews. Hospital shall allow BCBSM to conduct reasonable Reviews of Hospital's medical and billing records related to Covered Services provided to Members under this Agreement. Hospital shall receive 30 days advance written notice from BCBSM advising Hospital of the Review and setting forth the scope of the medical and billing records to be reviewed. Hospital shall provide BCBSM with on-site access during Hospital's regular business office hours to all appropriate medical and billing records of Covered Services to Members as may be necessary for benefit determination and/or verification of compliance with the requirements of the Utilization, Quality and Health Management Programs. At the request of BCBSM, Hospital shall provide BCBSM with copies of such requested medical and billing records within a reasonable time from the date of request and in exchange for reasonable payment. All Reviews shall be initiated and completed, including receipt by Hospital of a final Notice of Determination, within 18 months from the date of payment, excluding cases under appeal. The results of findings resulting from any Review undertaken pursuant to this Section shall be submitted in writing to Hospital's Chief Financial Officer, or designee, for comment.

b. Financial Audits. Hospital shall allow BCBSM to conduct reasonable Audits of Hospital's financial records. Such financial Audits shall be initiated and completed within 18 months of the filing of an acceptable cost report with BCBSM by Hospital. Hospital shall provide BCBSM with on-site access during Hospital's regular business office hours to all appropriate financial records as may be necessary for establishing appropriate payment liabilities. Hospital shall authorize its independent public accountants to share work papers, reports and other documents (except for third party reserve work papers) utilized in its annual financial audits as may be relevant to BCBSM's determination of appropriate payment liabilities. The findings resulting from any financial Audit undertaken pursuant to this Section shall be discussed with Hospital's Chief Financial Officer, or designee, in an exit conference prior to being subsequently submitted to Hospital's Chief Financial Officer, or designee, in writing for review.

2. Recovery.

a. Subject to the time limitations in Article VI, Section 1.a., BCBSM shall have the right of recovery if payments made by BCBSM are subsequently determined to have been erroneous pursuant to any Reviews conducted under this Agreement, except for Reviews associated with the incentive system.

b. Subject to the time limitations in Article VI, Section 1.,b, BCBSM shall also have a right of recovery for amounts resulting from a Financial Audit.

c. BCBSM shall have the further right to recover the amount of all Overpayments and other amounts ("BCBSM Receivables") due it under all contracts between BCBSM and Hospital through recoupment of and setoff against amounts due to Hospital from BCBSM under this Agreement.

d. Hospital shall have the right to recover the amount of all Underpayments and other amounts (Hospital Receivables) due it under all contracts between BCBSM and Hospital through recoupment of and set-off against amounts due to Hospital from BCBSM under this Agreement.

e. The expiration or termination of this Agreement shall not terminate or otherwise limit BCBSM's right of recovery from Hospital as set forth in this Article, or under any other provision of this Agreement. Upon termination or expiration of this Agreement, BCBSM may withhold an amount equal to reasonably anticipated BCBSM Receivables until a final audit is completed. In the event the final audit determines that Hospital owes BCBSM money, BCBSM may apply the withheld BCBSM Receivables against any amounts due to BCBSM under this Agreement or otherwise. BCBSM shall promptly pay to Hospital all withheld amounts in excess of the amounts due to BCBSM under this Agreement or otherwise.

3. Other Recoveries. Except for those situations indicated below, BCBSM recoveries for payments made to hospitals in error will be limited to two years from the original date of payment. Exceptions to this policy include verified duplicate and overpayments, workers' compensation cases, credits uncovered through fraud investigations, payments where BCBSM was verified in error as the primary insurer, payments issued to the wrong facility and payments for services not performed. Additional exceptions will be subject to CAP review.

## Article VII
Confidentiality

1. Medical and Administrative Records.

a. Preparation and Maintenance. Hospital will prepare and maintain medical and administrative records relating to its provision of Covered Services to Members, in such form and detail as is required by BCBSM, applicable medical standards and applicable law. Hospital will retain all Member medical records for at least as long as applicable law requires.

b. Confidentiality.

i. Hospital Requirements. Hospital will treat as confidential all Member medical records and the information contained therein, as well as aggregate data that could implicitly identify an individual. In accordance with its internal policies and procedures, and as required by law, Hospital will obtain appropriate consent from Members for release of medical records or any of the information contained therein to third parties.

ii. BCBSM Requirements. BCBSM will maintain confidentiality of Member-specific information, as well as aggregate data that could implicitly identify a Member. As a condition precedent to receiving benefits under a Certificate, BCBSM will require Members to agree to release of medical information from physicians and Hospitals related to the provision of Covered

Services. BCBSM may disclose Member-specific information to a Group for purposes of claims adjudication and verification, provided the recipient executes a written confidentiality and indemnification agreement that restricts use of the information to the above purposes and prohibits further disclosure.

c. Access to Records. Hospital will permit BCBSM to have access during normal working hours to Members' medical and administrative records and upon reasonable request to inspect and copy any medical and administrative records maintained by Hospital pertaining to Members. Upon request, BCBSM shall reimburse Hospital a reasonable amount for copying costs associated with copying records for BCBSM.

2. Hospital-Specific Information.

a. BCBSM will maintain the confidentiality of, and will not disclose to any third party, Hospital-specific Agreement modifications, payment rates, and Hospital-specific business or financial information not otherwise available to the public ("Confidential Information"). Except where disclosure is required by law, BCBSM may disclose Confidential Information to another party only with the prior written consent of Hospital, specifying the conditions under which it may be released. However, BCBSM may, without prior written consent of Hospital, disclose Confidential Information as defined in this subsection to a customer for purposes of audit and health plan administration, or to the MHA for modeling and other contract administration purposes, so long as the customer and MHA agree to restrict its use of the information to these purposes and agrees not to further disclose the information.

b. Analyses of Hospital's performance under this Agreement, for example, its relative cost position vis-à-vis other hospitals or benchmarks and findings under any Utilization Management and Quality Assessment Program (including measures used for incentive purposes) will not be considered Confidential Information. BCBSM may use and disclose such information without further authorization from Hospital. However, when BCBSM develops such reports, it will seek the input of hospitals through the CAP and not disclose any such information to the public without providing to the physicians or hospitals, including Hospital identified in the disclosure, in advance, a copy of the information. BCBSM will provide Hospital and the identified physicians a reasonable opportunity to comment on findings related to them.

c. Notwithstanding the above, and subject to prior notice being given to hospitals through the CAP, BCBSM is permitted to release Hospital-specific health care data for the purpose of allowing Subscribers, Plan sponsors, customers, consultants, BCBSA, BCBS plans or other BCBSM business partners to relatively compare the cost and level of quality of care offered by the Hospital. Hospital-specific health care data may include, but shall not be limited to, the following:

i. Provider demographic information

ii. Utilization information

iii. Quality of care measures and initiatives

iv. Service volumes

v. Small area analysis

vi. Credentialing information

vii. Outcome measures

viii. Patient satisfaction results

ix. Costs and similar health care data

Hospitals agree to provide or assist in the provision of such provider-specific health care data as reasonably requested by BCBSM. Upon written request of Hospital, BCBSM shall make available to Hospital a description of how BCBSM intends to use a particular category of provider-specific health care data, the methodology used in collecting and analyzing the data and a copy of the Hospital's data which BCBSM intends to disclose. To the extent Hospital can reasonably demonstrate, in writing, that any data which BCBSM intends to disclose is inherently inaccurate, Hospital shall notify BCBSM of its specific concerns. BCBSM shall make a good faith effort to resolve Hospital's concerns, provided, however, that BCBSM shall have the sole and final discretion, responsibility and authority over the content, dissemination and release of such data.

3. Mutual Indemnification. Each Party will defend, indemnify and hold harmless the other, its directors, officers, employees and agents from any claims, losses, costs or expenses (including reasonable attorney fees) arising out of or in connection with breach of these confidentiality provisions by the other Party.

4. Hospital/Patient Discussions. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations, Hospital shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by BCBSM or any other entity. Nothing in this Agreement shall prohibit Hospital from disclosing to the Member the general methodology by which Hospital is compensated under this Agreement, provided no dollar amounts or other specific terms of the compensation arrangement are mentioned to the Member. BCBSM shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Hospital in connection with services rendered solely because Hospital has in good faith communicated with one or more of its current, former or prospective patients regarding the provisions, terms or requirements of a Certificate as they relate to the health needs of such patient.

5. Survival of Terms. The obligations and duties set forth in this Article shall survive the termination of this Agreement.

IN WITNESS WHEREOF, the Parties hereby execute this Agreement by affixing their signatures to the attached Signature Document.

**SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF**

# Exhibit A

## QUALIFICATION STANDARDS

I. **Scope of Qualification Standards:**

A. These Qualification Standards apply to Hospitals providing short term general acute care, short-term acute psychiatric care and intensive rehabilitation programs and only to services, beds and facilities that are included within the scope of Hospital's license. Separate qualification standards have been established for sub-acute services of Hospital not included within the scope of Hospital's license.

II. **Licensure, Certification, Accreditation:**

A. Hospital must be licensed as required by the laws of the State of Michigan.

B. Hospital must comply with the certification standards established by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) for participation in the Medicare Program.

C. Hospital must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA) or the Commission on Accreditation of Rehabilitation Facilities (CARF), or such other accreditation organizations as may be approved through the CAP, unless Hospital is located in a rural census category. If Hospital is located in a rural census category, the accreditation requirements set forth in this subsection may be waived at the request of Hospital, if Hospital demonstrates that CMS certified Hospital's compliance with Medicare certification requirements on the basis of a survey conducted by an appropriate state agency.

III. **Certificate of Need:**

Hospital must comply with applicable Certificate of Need requirements of the Michigan Public Health Code.

IV. **Sponsorship, Ownership and Control:**

Hospital must have a governing body that is legally responsible for the conduct of the hospital. Hospital must have a governing body, or advisory body responsible to the governing body, that includes persons generally representative of the community in Hospital's service area.

V. **Financial**

Hospital shall follow generally accepted accounting principles and practices.

VI. **Utilization Management and Quality Assessment**

Hospital shall have programs of utilization management and quality assessment.

# Exhibit B

## REIMBURSEMENT

### I. Implementation

Unless otherwise indicated, the following inpatient and outpatient reimbursement methodologies will be effective with the start of Hospital's fiscal year beginning on or after July 1, 2006.

# Exhibit C

# UTILIZATION, QUALITY AND HEALTH MANAGEMENT PROGRAMS

BCBSM shall establish and administer the following Utilization, Quality and Health Management Programs. Hospital shall participate and cooperate with these Programs.

## I. Utilization, Quality and Health Management Programs

The purpose of the Utilization, Quality and Health Management Programs is to assess the Medical Necessity and quality of Covered Services provided to Members. The Utilization, Quality and Health Management Programs are the joint responsibility of BCBSM and Hospital.

## II. Utilization Management Program

The Utilization Management Program shall include: (1) Prenotification, (2) Precertification; Recertification; and Reviews.

A. Prenotification, Precertification and Recertification. Prenotification, Precertification and Recertification processes will be established from time to time by BCBSM. Prenotification, Precertification and Recertification shall not constitute a binding determination with respect to whether services meet all components of a Medical Necessity determination except as provided in Article III, Section 8.

B. BCBSM will monitor hospital data, as needed, to evaluate trends in utilization and performance, and to develop new programs.

C. Utilization Management Intervention Strategies. BCBSM shall impose appropriate interventions in order to address utilization problems identified through the Utilization Management Program as may be identified by BCBSM from time to time. BCBSM intervention strategies, criteria and standards shall be as set forth in published guidelines and criteria that may be developed, implemented and modified by BCBSM from time to time through the CAP.

## III. Quality Assessment Program

A. The Quality Assessment Program as it may be developed, implemented and modified from time to time, shall be directed toward strengthening the quality assessment process, standards and tools.

Hospitals shall report performance annually according to specifications and guidelines developed, implemented and modified by BCBSM.

B. Participating Hospitals will be reviewed quarterly through analysis of paid claim data. The primary purpose of the quarterly analysis is to monitor hospital trends and assure timely sharing of information which may assist hospital in achieving optimal quality performance.

C. The Quality Assessment Program may be composed of the following retrospective medical record Reviews to determine whether Covered Services are of appropriate quality: (1) Quality Screening Reviews and (2) Quality Studies.

D. BCBSM may propose appropriate interventions to address quality problems identified through the Hospital Claims Monitoring System and retrospective medical reviews for quality.

## IV. Criteria, Standards and Tools Used in the Utilization, Quality and Health Management Programs

BCBSM will provide Hospital with current copies of all utilization reviews and quality assessment clinical screening criteria, standards, protocols, policies and procedures relevant to the Utilization Management Program and Quality Assessment Program including, but not limited to, those used to determine whether Covered Services are Medically Necessary and met professionally recognized standards of care.

# Exhibit D

## APPEAL PROCESS

All references in this Exhibit to days are to calendar days.

### I. Appeals of Reimbursement Policies

A. General Requirements

BCBSM shall establish and communicate to Hospital a procedure by which Hospital may obtain a timely BCBSM decision of the interpretation and application of Reimbursement Policies as applied to Hospital's specific circumstances. Prior to taking any other action, Hospital shall submit any dispute concerning the proper interpretation and application of Reimbursement Policies as applied to Hospital's specific circumstances to BCBSM for its decision.

At the conclusion of each point in the appeal process, BCBSM will forward the findings to the Hospital. At the conclusion of the appeal or at any point in the appeal process, if the Hospital agrees with or chooses not to dispute the findings, the appropriate adjustments will be finalized.

If the Hospital disagrees with BCBSM's decision rendered during the appeal process and wishes to have a specific adjustment reviewed at a higher level, the Hospital may do so by submitting a request in writing within the time frame specified for each review level in this exhibit. The request must include the following:

- Area of dispute
- Reason for disagreement
- Dollar value of appeal
- Additional documentation specific to the area of dispute and an explanation of its relevance. Hospital must make a good faith effort to submit all such documentation with its appeal
- Fiscal years covered

B. Hospital Applications

If Hospital fails to meet any of the designated time frames, its appeal will be denied. If BCBSM fails to meet any of the designated time frames, Hospital may petition BCBSM in writing for an immediate decision. If BCBSM does not render a decision on all issues involved in Hospital's appeal within ten (10) days of receiving Hospital's petition, the appeal will be decided in favor of Hospital with respect to all issues not expressed in BCBSM's opinion, if any. Hospital must enter the process at the BCBSM Management Review level and must proceed through each level of the process.

Following is the appeals process:

1. BCBSM Management Review. If the Hospital disagrees with BCBSM's decision, the Hospital may request Management Review. The written request for the Management Review along with the required documentation listed above must be submitted within ninety (90) days of receipt of BCBSM's notification with respect to the determination under appeal. BCBSM will conduct the Management Review meeting and provide a written response to the Hospital. BCBSM will acknowledge receipt of the appeal within fourteen (14) days and will render a management decision within one hundred twenty (120) days of receipt of appeal.

2. Internal Review Committee (IRC). If Hospital disagrees with the final Management Review decision, Hospital may request review by the IRC within thirty (30) days of receipt of the Management Review decision. The request for review should be submitted in writing, by certified mail, to the Director of Provider Contracting. The IRC will schedule a hearing that shall occur within one hundred twenty (120) days of receipt of the request for IRC review and will notify Hospital of its decision within thirty (30) days after the hearing.

3. Provider Relations Committee. If Hospital disagrees with the decision of the IRC, it may request review by the Provider Relations Committee (PRC) of the BCBSM board of directors. Hospital must submit its request in writing, by certified mail for PRC review within thirty (30) days of receipt of the IRC decision letter. BCBSM will schedule a hearing before the PRC which shall occur within one hundred eighty (180) days of receipt of Hospital's request for PRC review. The PRC will issue its decision within thirty (30) days after the PRC meets to consider the appeal.

## II. Appeals of BCBSM Adverse Determinations

Hospital has the following appeal rights with respect to Prospective, Concurrent and Retrospective Reviews.

A. Prospective or Concurrent Reviews

BCBSM will provide an expedited appeal process for review of adverse determinations on imminent or ongoing services. If Hospital disagrees with an adverse determination on prospective or concurrent review, Hospital may request internal appeal. The Hospital must submit a written request to BCBSM within thirty (30) days of discharge. The request must include the following:

- Patient's name
- Contract number
- Dates of service
- Complete medical record
- Any additional supporting information

BCBSM will decide the appeal and report its decision to Hospital within thirty (30) days of receipt of Hospital's written request for appeal. If Hospital continues to disagree with BCBSM's determination, it may request an External Review as provided in Section C.

B. Retrospective Reviews

After the audit is complete, BBSM will notify Hospital of the audit determination in a reporting letter sent via certified mail. Hospital will have fifty (50) calendar days from receipt of the letter in which to submit a written request for internal review if it does not agree with the BCBSM determination. Hospital must submit written rationale and all supporting documentation explaining the basis for its disagreement with its request for Internal Review. The name of the attending physician must be included with the request.

Hospital's request for Internal Review, along with written rationale and all supporting documentation, must be postmarked no later than fifty (50) calendar days from its receipt of the reporting letter. BCBSM's decision will be maintained if Hospital does not submit its request, written rationale and all supporting documentation within this time frame.

BCBSM will notify Hospital of the Internal Review decision by letter postmarked no later than fifty (50) calendar days following its receipt of Hospital's request for Internal Review. Hospital's appeal will be granted if BCBSM does not respond within this time frame.

C. External Appeal

If the Hospital continues to disagree with BCBSM's determination under A. or B., the Hospital may request an External Appeal. BCBSM has no appeal rights and is bound by the decision if a Hospital chooses not to appeal.

Hospital must submit its written request for External Review within twenty (20) calendar days of receipt of BCBSM's decision. The request must include:

- Patient's name
- Contract number
- Dates of service

Neither party may submit to the external review agency any information or arguments not previously submitted to the other.

BCBSM will report the decision of the external peer review agency to Hospital within forty-five (45) days of receipt of Hospital's written request for appeal. The decision of the external peer review agency is final.

External appeals in cases involving Medical Necessity, site of care or quality of care will be reviewed by a peer review organization composed of practicing physicians. Cases involving DRG coding disagreement will be sent to an independent coding expert for a determination. (Disputes involving benefit determination are not appealable externally.)

In all cases in which the peer review agency upholds BCBSM's decision, Hospital will pay the cost of the appeal.

This Agreement is proprietary and confidential. Exhibit B of this Agreement can be released to Hospital's agents, contractors or consultants only if these parties sign a statement agreeing not to disclose the Agreement to third parties. Hospital cannot disclose Exhibit B to any other third parties without the prior written consent of BCBSM.


# PHA HOSPITAL

IN WITNESS WHEREOF, the parties, wishing to be bound by the terms and conditions of BCBSM's ***Second Amended and Restated Participating Hospital Agreement***, have affixed their signatures on this Signature Document, which is incorporated by reference in the Agreement.

HOSPITAL NAME (HOSPITAL FEDERAL TAX NAME) (dba, if applicable- to be used in directory)

INPATIENT SITE ADDRESS (for directory)

CITY STATE ZIP CODE

TELEPHONE NUMBER (for directory)

FEDERAL EMPLOYER IDENTIFICATION NUMBER

NUMBER ASSIGNED BY MEDICARE FOR BILLING BCBSM MEDICARE SUPPLEMENTAL EFFECTIVE DATE

BCBSM HOSPITAL FACILITY CODE (To be completed by BCBSM)

EFFECTIVE DATE OF AGREEMENT (To be completed by BCBSM)

**********

**HOSPITAL REPRESENTATIVE**

X
AUTHORIZED REPRESENTATIVE

NAME (Print or Type)

TITLE

DATE

**BCBSM REPRESENTATIVE**

X
AUTHORIZED REPRESENTATIVE

NAME (Print or Type)

TITLE

DATE

**PLEASE RETAIN THE ENCLOSED COPY OF THE AGREEMENT FOR YOUR RECORDS.**

**Please return *only* this Signature Document to:**

**Provider Contracting – MC B715**
**Blue Cross Blue Shield of Michigan**
**27000 W. Eleven Mile Rd..**
**Southfield MI 48034-2200**

# 2007 Hospital Pay-for-Performance Program

## Program Overview

The Blue Cross Blue Shield of Michigan Hospital Pay-for-Performance program gives short-term acute care hospitals the opportunity to earn additional amounts on their inpatient and outpatient payments. In 2007, a hospital with top performance in both quality and efficiency can earn up to an additional 4 percent of its inpatient and outpatient operating payments.

In 2007, the program will evaluate hospitals on the following components:

| Program component | Weight |
|---|---|
| Prequalifying conditions | None |
| Quality | 45% - 55% |
| Efficiency | 35% |
| Collaborative quality initiatives | 10% - 20% |

A detailed description of each of these components is provided in the following pages.

Hospital performance is evaluated on a calendar-year basis. The amount a hospital earns, based on its 2007 performance, will be effective July 1, 2008.

Hospitals also have the potential to earn up to an additional 1 percent based on an annual comparison of hospital costs in Michigan to those in other states in our geographic region. Unlike the measures noted above, this regional cost comparison is not hospital-specific. Instead, it is applied equally to all eligible hospitals. A detailed description of the regional cost comparison is provided in Attachment C.

**A note on hospital eligibility for the P4P program**

All short-tem acute care hospitals are eligible to participate in the program. However, the maximum amount a hospital is able to earn is determined by the amended and restated BCBSM Participating Hospital Agreement. If a hospital's reimbursement arrangement complies with this agreement, it is eligible to earn the amounts stated above. If its reimbursement arrangement does *not* comply with this agreement, the amount it can earn is limited to 4 percent of its inpatient operating payments only. These hospitals are also not eligible for the additional 1 percent based on the regional cost comparison.


***Contact**: Mike Ortwine, 248-448-8092, P4Phospital@bcbsm.com*

## Prequalifying Conditions

Hospitals must meet certain prequalifying conditions to be eligible to participate in the P4P program. Hospitals do not earn specific payments for meeting the prequalifying conditions.

In 2007, a hospital must meet the following three prequalifying conditions:

1. Publicly report performance on all applicable quality indicators to the Centers for Medicare & Medicaid Services.

   This first prequalifying condition is applicable to the entire program. If a hospital fails to meet the condition, it forfeits its eligibility for the entire P4P program.

2. Maintain participation in all selected collaborative initiatives for which it is eligible.

   This second prequalifying condition applies only to the CQI component of the program. If a hospital fails to meet the condition, it will forfeit its eligibility for payment under the CQI component, but it will not be precluded from earning payment for the quality or efficiency components of the program[1].

New in 2007

3. Implement and maintain specified culture of safety, medication and patient safety practices and patient safety technology. Specific requirements of this prequalifying condition are provided in Attachment A.

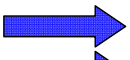
   This third prequalifying condition is new in 2007 and applies only to the quality component of the program. If a hospital fails to meet the condition, it will forfeit its eligibility for payment under the quality component, but it will not be precluded from earning payment for the efficiency or CQI components of the program.

## Quality 45% - 55%

In 2007, the weight of the P4P program quality component is between 45 percent and 55 percent.

Hospitals will be evaluated on the following six quality indicators:

1. Heart failure
2. Pneumonia
3. Surgical infection prevention



4. Acute myocardial infarction “all or none”

5. Central line-associated blood stream infection rates

New in 2007

6. Intensive care unit ventilator bundle

[1] A hospital that does not participate in a CQI for which it is eligible, and therefore forfeits this portion of the P4P program, may be reimbursed for its CQI costs under an alternative funding mechanism.

Two of the above indicators are new to the program in 2007. The first is the AMI "all or none" indicator, which will be scored at the patient level. This scoring methodology requires a hospital meet the requirement for **all** applicable measures for each patient. If one or more of the measures is not met, and the measure was not contraindicated, the hospital will not receive credit for that patient.

The second new indicator is the measure for ICU central line-associated blood stream infection rates. This measure is tracked by the Michigan Health & Hospital Associated via its Keystone: ICU project and is based on nationally recognized criteria.

A list of the specific measures that are included within each quality indicator is provided in Attachment B. Performance thresholds for each measure will be established and communicated to hospitals during the first quarter of 2007.

**Weight of the quality component and individual measures**

For each hospital, the weight of the quality component is determined by the weight of the collaborative quality initiative component. Together, these two components will equal 65 percent. Hospitals with a higher CQI weight will have a lower quality component weight. Conversely, hospitals with a lower CQI weight will have a higher quality component weight. The relationship between these two components is shown in the following table:

**Relationship of CQI and quality program weights**

| CQI | Quality | Total |
|---|---|---|
| 10% | 55% | 65% |
| 15% | 50% | 65% |
| 20% | 45% | 65% |

Within the quality component, all six quality indicators are weighted equally. For example, if the quality component is weighted at 45 percent, each of the six indicators is worth 1/6 of that amount, or 7.5 percent. If a hospital does not provide the relevant services or has an insufficient number of cases, it will not be scored on that indicator. The indicator's weight then will be reallocated across the remaining quality indicators.

## Efficiency 35%

In 2007, hospital efficiency is measured by hospitals' standardized inpatient cost per case relative to the statewide mean. The following table shows the amount of the efficiency component a hospital will earn, based on its position to the statewide mean:

| Hospital standardized cost per case relative to statewide mean | Efficiency component earned |
|---|---|
| More than 0.5 standard deviation below | 35% |
| Within 0.5 standard deviation, inclusive | 30% |
| More than 0.5 standard deviation above | 15% |
| More than 1 standard deviation above | None |

This comparison will be made using hospitals' 2005 standardized cost per case and the 2004 statewide mean, with the mean trended forward by the annual hospital update factor.

## Collaborative Quality Initiatives 10% - 20%

In 2007, hospitals will be evaluated on their participation in the following six CQIs. (This list remains unchanged from 2006.)

- Blue Cross Blue Shield of Michigan Cardiac Consortium
- Michigan Society of Cardiovascular and Thoracic Surgeons Quality Improvement Initiative
- Michigan Bariatric Surgery Collaborative
- Michigan Surgery Quality Collaborative
- Michigan Breast Oncology Initiative
- MHA Keystone project on hospital associated infections

**To qualify for this portion of the P4P program, a hospital must maintain participation in all selected CQIs for which it is eligible.**

The CQI component is weighted between 10 percent and 20 percent. For each hospital, the weight is determined by the number of CQIs in which a hospital is eligible to participate, as follows:

| Number of CQIs in which a hospital is eligible to participate | Weight of the CQI component |
|---|---|
| One or two | 10% |
| Three or four | 15% |
| Five or more | 20% |

## ATTACHMENT A - CULTURE OF SAFETY PREQUALIFYING CONDITION

A prequalifying condition of the 2007 Hospital P4P program requires hospitals to implement and maintain a specified culture of safety, medication safety and patient safety practices and patient safety technology. This prequalifying condition applies only to the quality component of the program. If a hospital fails to meet the condition, it will forfeit its eligibility for payment under the quality component, but it will not be precluded from earning payment for the efficiency or CQI components of the program.

The specific requirements of this prequalifying condition are as follows:

**Culture of safety**

A hospital must certify that its board-approved, multi-disciplinary patient safety plan (including medication safety) is reviewed, updated and accomplishes the following:

- Demonstrates that hospital leadership is actively involved in patient and medication safety by conducting executive patient safety rounds on a regular basis according to the plan
- Communicates patient and medication safety initiatives to patients and visitors

The results of the executive patient safety rounds and patient and visitor communication efforts should be integrated into reports to the hospital board committee overseeing the patient safety plan.

Hospitals must also conduct a hospital-wide cultural assessment of patient safety in either 2006 or 2007. The assessment must be conducted using a validated assessment tool, such as those developed by the Agency for Healthcare Research and Quality or the University of Texas. The results of the assessment should then be used to foster improvement.

**Medication safety practices**

- Hospitals must conduct an assessment of their hospitals using the *Institute for Safe Medication Practices® Self Assessment* on an annual basis.
- Hospitals must meet with a score of "D" or better the six ISMP criteria listed below. This score means that the item is considered fully implemented in some areas of the organization.
- Hospitals must also identify three additional ISMP criteria that they do not currently meet with a score of "D" or better and commit to work toward meeting the criteria.

Required ISMP criteria

1. The pharmacy computer system **automatically** screens and detects drugs to which patients may be allergic (including cross allergies) and provides a clear warning to staff during order entry. (ISMP No. 7)

2. A list of prohibited, error-prone abbreviations (for example, u, qd, MSO4, certain chemotherapy regimen acronyms) and unacceptable methods of expressing doses (by volume or number of tablets instead of weight, using trailing zeros for whole number doses, not using a leading zero for doses less than one) is established for all communication of drug information or orders (including in handwritten or preprinted orders, MARs and in electronic formats and computer screens). (ISMP No. 40)

3. Products with look-alike drug names and packaging that are known by the hospital staff to be problematic are stored separately and **not alphabetically**. (ISMP No. 53)

4. The types of PCA pumps used in the hospital are limited to two or less to maximize competence with their use. *Scoring guideline: Choose "not applicable" if you do not offer PCA in your hospital.* (ISMP No. 106)

5. Pharmacists and pharmacy technicians have easy access (e.g., on each computer terminal) to user-friendly, up-to-date, computerized drug information systems (e.g., MicroMedex, Facts and Comparisons), which include information on herbal and alternative medicines, **in the pharmacies**. (ISMP No. 18-1)

6. Prescribers and other non-pharmacy practitioners have easy access (e.g., on each computer terminal, palm devices) to user friendly, up-to-date, computerized drug information systems (e.g., MicroMedex, Facts and Comparisons), which include information on herbal and alternative medicines, **in all patient care areas**. (ISMP No. 18-2)

**Patient safety practices**

Hospitals are required to comply with six of the 10 National Quality Forum-endorsed safe practices listed in the following table. Hospitals must attest to the fact that they have completed the "Additional Specifications" associated with each chosen NQF practice. Hospital staffs must use their best judgment regarding documentation of risk. At a minimum, high-risk assessments must be documented in the patient record.

## ATTACHMENT A - CULTURE OF SAFETY PREQUALIFYING CONDITION

| NQF NUMBER | NQF PATIENT SAFETY PRACTICE | ADDITIONAL SPECIFICATIONS |
|---|---|---|
| 5. | Pharmacists should actively participate in the medication-use process, including, at a minimum, being available for consultation with prescribers on medication ordering, interpretation and review of medication orders, preparation of medications, dispensing of medications, and administration and monitoring of medications.<br><br>Applicable clinical care settings: All acute care settings. | ▪ Pharmacists should review all medication orders and the complete patient medication profile before medications are dispensed or made available for administration, except in those instances when review would cause a medically unacceptable delay.<br>▪ The review of medication orders should be documented in the patient's record.<br>▪ There should be explicit organizational policies and procedures regarding the role of pharmacists in the medication-use process.<br>▪ This practice shall be done in accordance with applicable state and federal laws.<br>▪ When a full-time pharmacist is not available onsite, then a pharmacist should be available by telephone or at another location that has 24-hour pharmacy service. |
| 11. | Ensure that written documentation of the patient's preference for life-sustaining treatment is prominently displayed in his or her chart.<br><br>Applicable clinical care settings: All acute care settings. | ▪ Create explicit organizational policies and procedures regarding patient preference for life-sustaining treatments. |
| 13. | Implement a standardized protocol to prevent the mislabeling of radiographs.<br>Applicable clinical care settings: All acute care settings. | ▪ Create explicit organizational policies and procedures regarding the labeling of radiographs. |
| 14. | Implement standardized protocols to prevent the occurrence of wrong-site procedures or wrong-patient procedures.<br><br>Applicable clinical care settings: All care settings where surgical or other invasive procedures are performed. | ▪ The surgeon or other relevant healthcare provider should clearly document the intended operative or intervention site in the patient's record, and this record should accompany the patient to the operating room or procedure room.<br>▪ The OR or procedure team should use a standardized checklist to verify the operative site in the surgical suite before surgery commences.<br>▪ The OR or procedure team should document the verification of the operative site in the patient's record.<br>▪ Whenever possible, document the patient's pre-operative verification in the OR record.<br>▪ The patient or someone who has first-hand knowledge of the proposed procedure and the informed consent discussion should clearly mark the operative or intervention site. |
| 15. | Evaluate each patient undergoing elective surgery for risk of ischemic cardiac event during surgery and provide prophylactic treatment of high-risk patients with beta-blockers.<br>Applicable clinical care settings: Acute care hospitals and other settings where elective surgery is performed. | ▪ Document the acute cardiac event risk assessment and findings in the patient's record.<br>▪ Create explicit organizational policies and procedures regarding the prevention of intra-operative myocardial ischemia. |

## ATTACHMENT A - CULTURE OF SAFETY PREQUALIFYING CONDITION

| NQF NUMBER | NQF PATIENT SAFETY PRACTICE | ADDITIONAL SPECIFICATIONS |
|---|---|---|
| 16. | Evaluate each patient upon admission and regularly thereafter for the risk of developing pressure ulcers. This evaluation should be repeated at regular intervals during care. Clinically appropriate preventive methods should be implemented consequent to the evaluation.<br><br>Applicable clinical care settings: Acute care hospitals, nursing homes and rehabilitation facilities. | ▪ Document the pressure ulcer risk assessment and prevention plan in the patient's record.<br>▪ Create explicit organizational policies and procedures regarding the prevention of pressure ulcers. |
| 17. | Evaluate each patient upon admission and periodically thereafter for the risk of developing deep vein thrombosis or venous thromboembolism. Utilize clinically appropriate methods to prevent DVT and VTE.<br><br>Applicable clinical care settings: Acute care hospitals, long-term care facilities and nursing homes. | ▪ Document the DVT and VTE risk assessment and prevention plan in the patient's record.<br>▪ Create explicit organizational policies and procedures for the prevention of DVT and VTE. |
| 20. | Adhere to effective methods of preventing central venous catheter-related blood stream infections.<br><br>Applicable clinical care settings: Acute care hospitals and all other settings where central venous catheters are used. | ▪ Create explicit organizational policies and procedures regarding the prevention of central venous catheter-related infections. |
| 23. | Evaluate each patient upon admission and regularly thereafter for risk of malnutrition. Employ clinically appropriate strategies to prevent malnutrition.<br><br>Applicable clinical care settings: Acute care hospitals, nursing homes and other long-term care facilities, rehabilitation facilities, psychiatric facilities and home care. | ▪ Document the malnutrition risk assessment and prevention plan in the patient's record.<br>▪ Create explicit organizational policies and procedures regarding the prevention of malnutrition. |
| 25. | Decontaminate hands with either a hygienic hand rub or by washing with a disinfectant soap prior to and after direct contact with the patient or objects immediately around the patient.<br><br>Applicable clinical care settings: All care settings. | ▪ Create explicit organizational policies and procedures regarding hand decontamination and the prevention of nosocomial infections. |

## ATTACHMENT A - CULTURE OF SAFETY PREQUALIFYING CONDITION

### Patient safety technology

Hospitals must implement a high-technology tool as a project, develop a project plan, implement the plan and report on the results at the end of the year. A list of tools from which hospitals may choose is shown on the following page.

The types of milestones the hospitals will be evaluated on for this component include:

- Assessing the applicability of the tool for the hospital (for example, evaluating the financing needs and effectiveness of the tool in reducing medical errors)
- Gaining support of hospital leadership
- Selecting a tool and committing to a software vendor
- Implementing a tool that can detect and respond to medication errors
- Using an existing tool to improve patient safety
- Providing dedicated training, support and maintenance for the tool

For hospitals that are already in late-stage development and implementation of a tool (including post-implementation), milestones will include:

- Selecting and prioritizing clinical decision support categories; selecting products and vendors
- Evaluating the effectiveness of the tool (for example, effectiveness in intercepting a standardized set of prescribing errors that carry a high risk of adverse drug events)
- Reporting progress in making the system available to hospital staff (**Note**: Progress refers to actual steps taken to provide one of the initiatives within the hospital setting.)

## ATTACHMENT A - CULTURE OF SAFETY PREQUALIFYING CONDITION

The high-technology tools that hospital may select are as follows:

- Automated dispensing carts (for example, Pyxis) that are linked to electronic medical records: These devices are freestanding carts or built-in cabinets with compartmentalized drawers containing unit-dose medications. Nurses can access the medications as floor stock or access can be restricted on a patient-specific basis. Once access to the cart is granted, a drawer or specific compartment opens to allow access to unit-dose medications. Studies have shown that medication error rates can decrease substantially only if these devices are linked with hospital information systems.
- Bar coding: A point-of-care tool that uses bar codes on patient wristbands, medications, intravenous admixtures, medical records, etc. to ensure correct care is delivered to the correct patient at the correct time by an identified caregiver.
- Computerized prescriber order entry: CPOE is an integrated application that allows clinicians to create orders with the help of decision-support tools that provide knowledge and guidance while the order is being created. Physicians enter an order directly into a computer system and that order is transmitted directly to lab, pharmacy and other designated areas of the hospital.
- Electronic medical records: A tool that allows electronic access to patient medical history. The tool allows immediate access to a patient's medical history from a common location and ensures that all authorized caregivers are viewing the same information.
- Intravenous pump alarm systems (for example, smart pumps): These computerized IV devices can be integrated with a hospital's medication system to ensure patients receive the correct medication by alerting medical workers in the case of potential errors. Smart pumps use software that can be programmed with a hospital's guidelines on correct drug dosages for different patients. If a nurse or physician inputs an incorrect order, the system will sound an alert and pause the drug delivery or shut the pump down entirely.
- Personal digital assistants: PDAs can help reduce medication errors by providing the caregiver with access to reference information on drugs, drug-dose calculators and tools for managing infectious disease at the point-of-care. Wireless communications using PDAs can also be used to transmit medical information from one caregiver to another and to transcribe electronic prescriptions.
- Robotics for dispensing prescriptions: An automated high-technology tool that uses bar code technology to mechanically "pick" repackaged unit-dose medications, which are then sent to designated areas of the hospital for storage and administration. This tool helps to automate the drug selection process.
- Systems to capture error reporting (e.g., Medmarx$^{SM}$): These are electronic, standardized programs used by hospitals to report and track medical errors in an anonymous fashion. Caregivers can view medication errors that have been reported and learn from past experiences to develop new strategies to prevent future errors. The type of information collected can include error type, location within the hospital, level of staff involved, products, and factors contributing to the error.

## ATTACHMENT B – QUALITY INDICATORS

Hospitals are evaluated on their performance on six quality indicators. The individual measures that are evaluated within each quality indicator are shown below. Each of these measures is based on national standards, such as CMS and JCAHO core measures.

1. **Heart failure**

   - Assessment of left ventricular function
   - Left ventricular ejection fraction less than 40 percent prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers at discharge.
   - Discharge instructions

2. **Pneumonia**

   - Percent of patients administered initial antibiotic within four hours of hospital arrival.
   - Initial antibiotic selection (for non-intensive care unit patients) consistent with current recommendations
   - Pneumococcal vaccine (screening or administration) prior to discharge

3. **Surgical infection prevention for select surgeries**

   - Prophylactic antibiotic received within the hour prior to surgical incision
   - Prophylactic antibiotics discontinued within 24 hours after surgery end time (excluding CABG and other cardiac and vascular surgery)

   Surgical infection prevention measures are scored for the following select surgeries:

   − Coronary artery bypass graft and other cardiac surgery
   − Hip and knee arthroplasty
   − Colon surgery
   − Hysterectomy
   − Vascular surgery

4. **Acute myocardial infarction "all or none" indicator**

   The "all or none" indicator for AMI will be based on the following five individual measures:

   - Aspirin at arrival
   - Aspirin prescribed at discharge
   - ACEI or ARB for left ventricular systolic dysfunction
   - Beta-blocker prescribed at discharge
   - Beta-blocker at arrival

   **Note**: The "all or none" AMI measure will be scored at the patient level. This scoring methodology requires a hospital meet the requirement for **all** applicable measures for each patient. If one or more of the measures is not met, and the measure was not contraindicated, the hospital will not receive credit for that patient.

The AMI all-or-none measure is based on the measures CMS has included in its Appropriate Care Measures in the eighth scope of work. The initial performance threshold for this indicator will be determined using 2006 performance data.

**5. Central line-associated bloodstream infections per 1000 central line days.**

The rate of central line-associated blood stream infections in adult ICUs. The rates are reported using the number of blood stream infections divided by the number of days a patient had one or more central lines in place. This number is multiplied by 1,000 to give a rate of central line-associated blood stream infections per 1,000 central line days.

$$\frac{\text{Number of central line-associated BSIs}}{\text{Number of central line days}} \times 1{,}000$$

This measure is consistent with the National Healthcare Safety Network system from the Centers for Disease Control and Prevention. The initial performance threshold for this measure will be determined using 2006 performance data.

**6. Ventilator bundle measures**

- Assess weaning — Proportion of ventilator patients receiving care in the ICU, and without contraindications, who have had a trial of spontaneous breathing or the measurement of a rapid-shallow breathing index to determine the patient's readiness for mechanical ventilation removal.

- Follow commands — Proportion of ventilator patients receiving care in the ICU, and without contraindications, who are awake enough to follow simple commands.

- Head of bed greater than 30 degrees — Proportion of ventilator patients receiving care in the ICU, and without contraindications, who have the head of their bed elevated to 30 degrees or higher to reduce the risk of acquiring ventilator-associated pneumonia.

- DVT prophylaxis — Proportion of ventilator patients receiving care in the ICU who receive chemical or mechanical prophylaxis as a means of reducing the risk of deep vein thrombosis.

- SUD prophylaxis — Proportion of ventilator patients receiving care in the ICU who receive Stress Ulcer Disease prophylaxis as a means of reducing the risk of stress-related gastrointestinal hemorrhage.

## ATTACHMENT C – Regional Benchmark Cost Comparison

Hospitals have the potential to earn up to an additional 1 percent of their combined inpatient and outpatient operating payments based on a comparison of the statewide average cost-per-adjusted admission* with a regional benchmark. This is not a hospital-specific measure. Instead, it is applied equally to all eligible hospitals participating in the Hospital P4P program.

**Benchmark comparison**

According to data from the American Hospital Association, the Michigan cost-per-adjusted admission in 2004 was 3.7 percent lower than the average of its regional peers. It was also the lowest of all six states in its region.**

A similar comparison will be made in 2007 using the most recently available data. Hospitals will be awarded up to 1 percent based on the following two comparisons:

1. If the Michigan cost-per-adjusted admission stays the same or improves relative to the regional mean, hospitals will earn between 0.5 and 1 percent. If the Michigan cost-per-adjusted admission deteriorates relative to the regional mean, hospitals will not earn an amount based on this first comparison.

The amount hospitals earn under this first comparison will be determined as follows:

| Michigan cost-per-adjusted admission relative to regional mean | Amount earned |
|---|---|
| Less than 3.5% below | None |
| 3.5% to 3.9% below (that is, status quo) | 0.5% |
| Greater than 3.9% below | 1.0% |

2. If hospitals earn less than the full 1 percent based on the first comparison, they will be able to earn an additional 0.5 percent if the Michigan cost-per-adjusted admission remains lower than all other states in the region. If the Michigan cost-per-adjusted admission does not remain lower than all other states in the region, hospitals will not earn this additional 0.5 percent.

The total amount hospitals earn based on these two comparisons will not exceed 1 percent.

**Only hospitals whose reimbursement arrangement complies with the amended and restated Participating Hospital Agreement are eligible for an additional payment based this regional cost comparison.**

* Adjusted admissions = inpatient admissions + outpatient equivalent admissions
Outpatient equivalent admissions = outpatient revenue ÷ inpatient revenue per admission

** The region includes Michigan, Wisconsin, Illinois, Ohio, Indiana and Pennsylvania.

October 21, 2005

**PHA Advisory Committee Update No. 29**

Dear [Chief Executive Officer]:

The PHA Advisory Committee recently approved revisions to the PHA Incentive Program for 2006. These revisions were recommended by the Incentive Program Technical Advisory Committee and are based upon existing elements of the program.

## Due dates to remember

**Dec. 1, 2005:**

- 2005 Patient safety certification and implementation reports
- 2005 Community health report
- 2006 Community health plan
- CEO/President attestation

**Jan. 16, 2006:**

- 2005 quality indicator performance reports

The revisions include:

- Elimination of the indicator for acute myocardial infarction.
- Addition of a measure to both the heart failure and the pneumonia indicators.
- All hospitals with an ICU are asked to report on five ventilator bundle measures, whether or not they participate in the MHA Keystone project.
- The remaining patient safety measures are available only to hospitals that do not have an ICU. These measures have been updated for 2006.

All of the changes are described in detail in Attachment A. For your convenience, a table summarizing the proposed changes is provided on the last page of Attachment A. A detailed description of the full program will also be made available on our Web site, **www.bcbsm.com\providers\pha.** All revisions will be effective Jan. 1, 2006.

Please note the reports, shown above, that are due to BCBSM in the next few months. The forms needed to complete these reports are available in PDF format at our website. If you prefer an electronic version of these documents or have any questions completing the reports, please contact Michael Ortwine at (248) 448-8092 (mortwine@bcbsm.com).

We thank you for your continued efforts to improve the quality of care.

Sincerely,

Michael R. Schwartz
Senior Vice President
Network Relations, Contracting & Pharmacy Services

cc: [CFO]
Quality Management Director
Utilization Management Director
Medical Director
Pharmacy Director

# BCBSM PHA INCENTIVE PROGRAM

## 2006 Program Changes

Changes to the PHA Incentive Program for 2006 are described below. A full description of all program measures can be found at the BCBSM Web site, www.bcbsm.com\providers\pha.

## QUALITY INDICATORS — 60 percent

The number of quality indicators that hospitals are expected to report on is reduced from four to three, specifically:

### Acute myocardial infarction

- The AMI indicator is eliminated for 2006. The weight for this indicator is transferred to the remaining three quality indicators.

### Heart failure

- The weight for this indicator is increased to 20 percent.
- The following JCAHO core measure for discharge instructions is added.

  *Heart failure patients discharged home with written instructions or educational material given to patient or care giver at discharge or during the hospital stay addressing **all** of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.*

- All six elements in the discharge instruction must be met.

### Surgical infection prevention

- The weight for this indicator is increased to 20 percent.
- No other changes are made to this indicator.

### Pneumonia

- The weight for this indicator is increased to 20 percent.
- The following JCAHO core measure for pneumococcal vaccination is added.

*Pneumonia patients age 65 and older who were screened for pneumococcal vaccine status and were administered the vaccine prior to discharge, if indicated.*

# BCBSM PHA INCENTIVE PROGRAM
## 2006 Program Changes

**Continued**

## PATIENT SAFETY – ICU MEASURES 30 percent

Previously, only hospitals that participated in the MHA Keystone ICU project were scored on their performance on five ventilator bundle measures (shown below). In 2006, all hospitals with an ICU must report on these measures, regardless of whether or not they participate in the MHA Keystone ICU Project. Hospitals with an ICU will no longer be eligible to earn credit for the alternative patient safety measures.

The five ICU ventilator bundle measures are as follows:

- Assess weaning
- Follow commands
- Head of bed greater than 30 degrees
- DVT prophylaxis
- SUD prophylaxis

A description of each measure is provided in Attachment B.

Hospitals that participate in the MHA Keystone ICU project in 2006 will report their data to the MHA. The MHA will forward their performance rates to BCBSM.

Hospitals that do not participate in Keystone in 2006 will report their data directly to BCBSM. Reporting specifications will be available at the BCBSM Web site, www.bcbsm.com\providers\pha, or by contacting Michael Ortwine at (248) 445-8092 (mortwine@bcbsm.com)

Hospitals that reported on these measures in the past (via participation in Keystone) will no longer receive credit for timely/accurate data submission. Instead, these hospitals will only be scored against performance thresholds, with each of the measures weighted at 6 percent. The performance thresholds and reporting periods will be shared with hospitals early in 2006.

Hospitals that have not reported on these measures in the past will receive credit for the following:

- Timely data collection and submission
- Population of ICU fields in the Michigan Inpatient Database

Each of these measures is worth 15 percent.

# BCBSM PHA INCENTIVE PROGRAM
## 2006 Program Changes

**Continued**

## PATIENT SAFETY 30 percent
## Alternative Patient Safety Measures

Only hospitals that do not have an ICU can earn credit for the alternative patient safety measures. Modifications to these measures for 2006 are as follows:

1. Culture of safety - 5 percent

   A requirement is added that hospitals conduct a house-wide cultural assessment of patient safety using a validated assessment tool, such as those developed by the Agency for Healthcare Research and Quality (AHRQ) or the University of Texas. The results of the assessment should then be used to foster improvement.

2. Medication safety practices - 5 percent

   Hospitals are asked to comply with all 10 of the Institute of Safe Medication Practices Medication Safety practices shown in Attachment C.

3. Patient safety practices - 10 percent

   Hospitals are asked to comply with three additional (for a total of six) National Quality Forum Endorsed Safe Practices. Five additional NQF practices have been added to the list from which hospitals may choose (see Attachment D).

4. Patient safety technology - 10 percent

   - The requirement that hospitals implement diagnosis-specific standing orders is eliminated.

   - The weight for high-technology tools is increased to 10 percent

## HEALTH OF THE COMMUNITY 10 percent

There are no changes to this component for 2006.

# BCBSM PHA Incentive Program

## Comparison of 2005 and 2006 Program Measures

| Topic | 2005 | 2006 |
|---|---|---|
| **Quality Indicators** | **60%** | **60%** |
| Measurement<br>• Acute myocardial infarction<br>• Heart failure<br>• Pneumonia<br>• Surgical infection prevention | Four out of four clinical areas<br>15% each | Three out of three clinical areas<br>20% each<br>(AMI measures eliminated, HF and PN measures expanded) |
| **Patient Safety Measures** | **30%** | **30%** |
| ICU Ventilator Bundle Measures<br>• Assess weaning<br>• Follow commands<br>• Head of bed greater than 30 degrees<br>• DVT Prophylaxis<br>• SUD Prophylaxis | Required only for hospitals participating in the MHA Keystone ICU Project. | Required for all hospitals with an ICU. |
| Alternative Patient Safety Measures | Available only to non-Keystone participating hospitals | Available only to non-ICU hospitals |
| Culture of safety | 5% | 5% - added validation tool requirement |
| Medication Safety Practices (ISMP) | 5% - Five of 10 practices | 5% - Ten of 10 practices |
| Patient safety practices (NQF) | 10% - Three of five practices | 10% - Six of 10 practices |
| Diagnosis-specific standing orders | 5% | Eliminated |
| High-technology tools | 5% | 10% |
| **Health of the Community** | **10%**<br>Limited to tobacco control or physical activity and nutrition | **10%**<br>No changes |

## ICU VENTILATOR BUNDLE MEASURES

**Assess weaning** – Hospitals should report the proportion of ventilator patients receiving care in the ICU, and without contraindications, who have had a trial of spontaneous breathing or the measurement of a rapid-shallow breathing index to determine the patient's readiness to have mechanical ventilation removed.

**Follow commands** – Hospitals should report the proportion of ventilator patients receiving care in the ICU, and without contraindications, who are awake enough to follow simple commands.

**Head of bed greater than 30 degrees** – Hospitals should report the proportion of ventilator patients receiving care in the ICU, and without contraindications, who have the head of their bed elevated to 30 degrees or higher to reduce the risk of acquiring ventilator associated pneumonia.

**DVT prophylaxis** – Hospitals should report the proportion of ventilator patients receiving care in the ICU who receive chemical or mechanical prophylaxis as a means of reducing the risk of deep vein thrombosis.

**SUD prophylaxis** – Hospitals should report the proportion of ventilator patients receiving care in the ICU who receive Stress Ulcer Disease prophylaxis as a means of reducing the risk of stress-related gastrointestinal hemorrhage.

## Institute for Safe Medication Practices Self-Assessment Survey

## 2006 Criteria

1. Allergies are prominently visible on each patient-specific screen for all electronically displayed medication systems and records (for example, CPOE screens, pharmacy computer screens accessed during order entry, automated dispensing cabinet screens, electronic MARs). (ISMP #5)
2. Minimum and maximum dose limits have been established for parenteral medications titrated to effect (for example, insulin infusions, dopamine, dobutamine), which when approached (fall below minimum doses or exceed maximum doses), require notification of the prescriber for further instructions regarding the dose or possible discontinuation of the medication. (ISMP #9)
3. High-alert drugs used within the organization have been defined, identified, and communicated to all practitioners who prescribe, dispense and administer the products. (ISMP #11)
4. The hospital's ability to adequately monitor and manage the anticipated adverse effects of a medication is investigated, documented, considered by the pharmacy and therapeutics committee (or other interdisciplinary team), and addressed before adding the medication to the formulary. (ISMP #12)
5. The pharmacy computer is tested after adding a new drug to verify that important clinical warnings (e.g., serious drug interactions, allergies, cross allergy alerts, maximum dose limits) are functional; and if a serious alert is not yet functional through the drug information system vendor, a temporary free text alert is added so that it appears on the screen during order entry. (ISMP #13)
6. The pharmacy computer system is directly interfaced with the laboratory system to automatically alert practitioners to the need for potential drug therapy changes (ISMP #14).
7. Prescribers have easy access to an electronic or computer-generated medication for each patient (which lists all current and recently discontinued medications), and they review this profile on a daily basis to verify the accuracy of order interpretation and as a reference when planning the patient's discharge medications. (ISMP #15)
8. Medications brought into the health facility by a patient or family member are not administered to the patient until an authorized prescriber has approved their use and a pharmacist (or other qualified practitioner when a pharmacist is unavailable) has visually inspected the medications and containers to verify the drugs' identity and proper labeling and packaging to guide safe drug administration. (ISMP #16)
9. Syringes of medications prepared for use during anesthesia are labeled with the drug name, strength and or concentration, and date or time of expiration. (ISMP #17)
10. A convened multidisciplinary team routinely evaluates the literature for new technologies and successful evidence-based practices that have been effective in reducing error in other organizations to determine if it can improve its own medication management system. (ISMP #33)

## National Quality Forum Endorsed Safe Practices
## 2006 Criteria

1. Pharmacists should actively participate in the medication-use process, including, at a minimum, being available for consultation with prescribers on medication ordering, interpretation and review of medication orders, preparation of medications, dispensing of medications, and administration and monitoring of medications. (NQF Practice #5)
2. Ensure written documentation of the patient's preference for life-sustaining treatment is prominently displayed in his or her chart. (NQF Practice #11- added for 2006)
3. Implement standardized protocols to prevent the occurrence of wrong-site procedures or wrong-patient procedures. (NQF Practice #14)
4. Evaluate each patient, upon admission, and periodically thereafter, for the risk of developing deep vein thrombosis (DVT)/venous thromboembolism (VTE). Utilize clinically appropriate methods to prevent DVT/VTE. (NQF Practice #17)
5. Implement a standardized protocol to prevent mislabeling of radiographs. (NQF Practice #13 - added for 2006)
6. Evaluate each patient undergoing elective surgery for risk of ischemic cardiac event during surgery, and provide prophylactic treatment of high-risk patients with beta-blockers. (NQF Practice #15 - added for 2006)
7. Evaluate each patient upon admission, and regularly thereafter, for the risk of developing pressure ulcers. This evaluation should be repeated at regular intervals during care. Clinically appropriate preventative methods should be implemented consequent to the evaluation. (NQF Practice #16 - added for 2006)
8. Adhere to effective methods of preventing central venous catheter-related blood stream infections. (NQF Practice #20)
9. Evaluate each patient upon admission, and regularly thereafter, for the risk of malnutrition. Employ clinically appropriate strategies to prevent malnutrition. (NQF Practice #23 - added for 2006)
10. Decontaminate hands with either a hygienic hand rub or by washing with a disinfectant soap prior to and after direct contact with the patient or objects immediately around the patient. (NQF Practice #25)

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# Hospital Provider Class Plan

# Table of Contents

_Toc134322848

# Provider Class

A provider class includes health care facilities or health care professionals who have a contract or reimbursement arrangement with BCBSM to render services to BCBSM's members. Qualification standards and the services for which reimbursement is made may differ for the types of providers within a provider class.

## Definition

This plan includes all short-term general acute care hospitals, short-term acute psychiatric care hospitals, and intensive rehabilitation programs. Hospitals provide inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons requiring the daily direction or supervision of a physician.

## Scope of Services

The scope of the hospital's licensure covers a variety of inpatient acute and outpatient services. Hospital services range from in-hospital physician care, general nursing care, overnight stay, surgery including all related surgical services, obstetric, rehabilitation, anesthesia, lab, x-rays, equipment supplies, and drugs.

# PA 350 Goals and Objectives

Provider class plans are developed and maintained pursuant to section 504 of PA 350, which requires BCBSM to provide subscribers reasonable cost, access to, and quality of health care services in accordance with the following goals and objectives.

## Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." The goal is derived through the following formula:

$$\left( \frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

Where "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where "REG" means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

### Objectives

- Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions
- Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participating agreement

# Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

## Objectives

- Provide direct reimbursement to participating providers that render medically necessary, high-quality services to BCBSM members
- Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participating agreement and its administration
- Maintain and periodically update a printed or Web site directory of participating providers

# Quality of Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

## Objectives

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards
- Obtain continuous input from hospital through the Contract Administration Process
- Meet with provider organizations such as Michigan Health and Hospital Association to discuss issues of interest and concern
- Maintain and update, as necessary, an appeals process that allows participating providers to appeal reimbursement policies disputes or disputes regarding utilization review audits

# BCBSM Policies and Programs

BCBSM maintains a comprehensive set of policies and programs that affect its relationship with health care providers. These policies and programs are designed to help BCBSM meet the PA 350 goals and objectives by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the PA 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

## Provider Participation

Providers may formally participate with BCBSM or, with respect to some provider classes, providers may participate on a per-claim basis. To formally participate, providers must sign a participation agreement with BCBSM that applies to all covered services the provider renders to BCBSM members. To participate on a per-claim basis, providers must indicate on the claim form that they are participating for the services reported.

### Participation Policy

Participation for hospitals is on a formal basis only which means there is no "per-claim" participation. Hospital services rendered by a nonparticipating hospital are for the most part, not reimbursed. In order to participate, providers must meet all of BCBSM's qualification standards.

### Qualification Standards

All hospitals may apply to participate with BCBSM. Standards for formal participation include, but are not limited to the items listed below. Hospitals' credentials are periodically reviewed to ensure participation requirements are maintained.

Participating hospitals must meet the following qualifications:

- Michigan licensure as an acute hospital and/or as a psychiatric care hospital or unit
- Medicare certification as a hospital
- Accreditation from one of the following organizations:[1]
  - The Joint Commission on Accreditation of HealthCare Organization (JCAHO)
  - The American Osteopathic Association
  - The Commission on Accreditation of Rehabilitation Facilities

[1] This requirement may be waived if the hospital is located in a rural census category which is further explained in Exhibit A of the attached Participating Hospital Agreement.

- An accreditation organization approved through the Contract Administration Process defined in the Participating Hospital Agreement

- Compliance with applicable Certificate of Need requirements of the Michigan Public Health Code
- Written policies and procedures that meet generally accepted standards for hospital services to assure the quality of patient care and demonstrate compliance with such policies and procedures
- Compliance with generally accepted accounting principles and practices
- Governing board that is legally responsible for the total operation of the facility, and for ensuring that quality medical care is provided in a safe environment. The governing board, or as an alternative, a community advisory board responsible to the governing board, shall include persons representative of a cross section of the community who are interested in the welfare and proper functioning of the hospital as a community facility.
- Absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review, and absence of fraud or illegal activities

### Termination of Contract

The participation agreement may be terminated immediately by BCBSM if the provider fails to meet any qualification standard. It can be terminated by either party, with or without cause, upon 120 days written notice to the other party. Other stipulations for terminating the participation agreement are outlined in the Participation Hospital Agreement.

## Provider Programs

BCBSM strives to ensure that members receive appropriate and quality care through a combination of provider communications, education, and quality assurance programs.

### Utilization Management Initiatives

BCBSM works to ensure that only medically necessary services are delivered to members through utilization management and quality assessment programs. Details of these programs can be found in Exhibit C of the Participating Hospital Agreement.

### Communications and Education

BCBSM provides the following resources to communicate with and educate hospital providers:

- The Participating Hospital Agreement Advisory Committee is committed to providing support to the hospital community. The committee meets on an ongoing basis to offer advice and consultation on topics of interest and concern.

- *The Record*, *Hospital Update* and *Physician Update*, are BCBSM publications that communicate current information regarding billing guidelines, policy changes, clinical news and other administrative issues.
- BCBSM's Web site and online manual provide information on how to do business with BCBSM including billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements, the Participating Hospital Agreement, and its administration. BCBSM maintains and updates the Web site and manual as necessary.
- A provider directory on the BCBSM Web site which includes a current list of participating hospital providers
- Provider consulting services to offer assistance to facility staff
- Continuing medical education seminars
- The liaison process such as the Contract Administration Process though which hospitals provide input and recommendations to BCBSM regarding its programs and polices.

### Performance Monitoring

- Hospital providers are surveyed regularly to ensure that qualification standards are maintained and up-to-date.
- Suspected fraudulent activity, reported to BCBSM by providers, subscribers, and BCBSM staff, is referred to Corporate Financial Investigations for further investigation.
- Several types of audits are performed that work to ensure that providers rendered services appropriately and within the scope of members' benefits.

### Appeals Process

BCBSM's appeals process allows hospitals the right to appeal reimbursement policies or adverse determinations of a utilization review audit. The process is described in Exhibit D of the Participating Hospital Agreement.

## Reimbursement Policies

BCBSM reimburses participating hospitals for covered services deemed medically necessary by BCBSM. Payment is limited to the lesser of the facility's charge or BCBSM's reimbursement level.

## Covered Services

BCBSM reimburses only for covered services when provided by a participating hospital in accordance with member certificates.* Services provided at a hospital include but are not limited to:

- Room and board
- Surgery
- Maternity care and delivery
- Newborn care
- Emergency treatment
- Dialysis
- Physical therapy
- Chemotherapy
- Pathology and laboratory
- Radiology – diagnostic
- Observation bed
- Medical supplies

## Reimbursement Methods

Reimbursement methods are based on hospitals' Peer Group designation. Specifics of the reimbursement structure can be found in Exhibit B of the attached Participating Hospital Agreement.

### *Peer Groups 1-4 Inpatient and Outpatient Services*

Peer Groups 1 through 4 include larger and medium sized acute care general hospitals.

Inpatient services and outpatient surgery, laboratory, radiology, physical therapy, occupational therapy and speech therapy services are reimbursed on a prospective price basis.

Inpatient prices are determined using Medicare's diagnostic related groupings (DRGs), plus a hospital specific amount for capital, graduate medical education, uncompensated care and margin. Additional amounts are reimbursed for qualified catastrophic cases.

Prices for outpatient surgery, laboratory, and radiology services are based on freestanding (facility and professional) provider levels. Prices for physical therapy, occupational therapy and speech therapy services are based on freestanding provider levels, plus a hospital specific amount for uncompensated care and margin. Freestanding provider levels are based on community

* Emergency services may also be covered by an accredited nonparticipating hospital.

pricing which is founded on the premise that payment for services provided in a hospital or non-hospital setting should be the same.

Hospitals have the opportunity to earn additional amounts on both their inpatient and outpatient payments under a Pay-for-Performance program.

Inpatient prices are updated annually using a formula that is based on the National Hospital Input Price Index (NHIPI). BCBSM does not guarantee that the annual updates will result in increased reimbursement. Hospitals' reimbursement and cost levels will be assessed every three years to determine whether there is a need for pricing adjustments.

Prices for outpatient laboratory, radiology, physical therapy, occupational therapy, speech therapy, and office-based surgery services are updated annually using the professional physician fee updates which is based on the Centers for Medicare and Medicaid Services' Resource Based Relative Value Scale system and a BCBSM conversion factor. BCBSM does not guarantee that the annual updates will result in increased reimbursement.

Other outpatient services may be cost-based until transitioned to community pricing. Outpatient cost-based services that are not routinely available through community providers will be transitioned to fixed statewide base prices using detailed claims information reported by hospitals in accordance with guidelines established by BCBSM.

## *Peer Group 5 Inpatient and Outpatient Services*

Peer Group 5 consists of small rural hospitals that are reimbursed a percent of charges for both inpatient and outpatient services, not to exceed 100 percent of their covered charges. The reimbursement for Peer Group 5 is hospital-specific. Hospitals must attest that their rates are at least as favorable as those for other non-governmental commercial insurers.

Hospitals will participate in a Pay-for-Performance program that will put a portion of the hospital reimbursement at risk.

The reimbursement levels for inpatient and outpatient services are updated annually using the formula that is used by Peer Groups 1 through 4.

## *Peer Groups 6-7 Inpatient and Outpatient Services*

Peer Groups 6 and 7 consist of psychiatric and rehabilitation hospitals and Medicare-exempt psychiatric and rehabilitation units of acute care hospitals.

Inpatient services are reimbursed based on the lesser of hospital's covered charge or BCBSM's per diem level. Annual updates are determined using the same update factor as Peer Groups 1 - 4. BCBSM does not guarantee that the annual updates will result in increased reimbursement.

Outpatient services are reimbursed the same as Peer Groups 1 – 4.

### *Non-Acute Services*

Other hospital-based non-acute services that can be provided under another provider class plan such as, but not limited to, residential substance abuse, home health care agencies, and skilled nursing facilities will be reimbursed using a hospital-specific cost-to-charge ratio set at a level not to exceed 1.0.

BCBSM may require that these services be considered "freestanding" and that they be reimbursed under a separate agreement. In such cases, the hospital will be granted participation status as a freestanding entity and will be given a reasonable amount of time to comply with such standards.

### *Alternative Reimbursement Arrangement*

BCBSM may consider alternative reimbursement methodologies such as "bundled" or "fixed" price arrangements covering all services per episode of care, where the reimbursement methodologies in this plan are not appropriate for payment of certain services, such as bone marrow transplants. All such alternative reimbursement methodologies will be determined through the Contract Administration Process.

## Hold Harmless Provisions

Participating hospitals agree to accept BCBSM's payment as payment in full for covered services. Member copayments or deductibles are subtracted from BCBSM's payment before the provider is reimbursed and are the member's responsibility. Participating hospitals must hold members harmless from the following:

- Balance billing for covered services
- Liability for services that are not covered because they are not medically necessary or are experimental, unless the member agrees in writing to pay for the services before they are provided
- Liability for covered services provided but not billed to BCBSM within a prescribed time frame

# Participating Hospital Agreement

The Participating Hospital Agreement is attached.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# Hospital Provider Class Plan



July 2007 Hospital

# Table of Contents

_Toc134322848

# Provider Class

A provider class includes health care facilities or health care professionals who have a contract or reimbursement arrangement with BCBSM to render services to BCBSM's members. Qualification standards and the services for which reimbursement is made may differ for the types of providers within a provider class.

## Definition

This plan includes all short-term general acute care hospitals, short-term acute psychiatric care hospitals, and intensive rehabilitation programs. Hospitals provide inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons requiring the daily direction or supervision of a physician.

## Scope of Services

The scope of the hospital's licensure covers a variety of inpatient acute and outpatient services. Hospital services range from in-hospital physician care, general nursing care, overnight stay, surgery including all related surgical services, obstetric, rehabilitation, anesthesia, lab, x-rays, equipment supplies, and drugs.

# PA 350 Goals and Objectives

Provider class plans are developed and maintained pursuant to section 504 of PA 350, which requires BCBSM to provide subscribers reasonable cost, access to, and quality of health care services in accordance with the following goals and objectives.

## Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." The goal is derived through the following formula:

$$\left( \frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

Where "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where "REG" means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

### Objectives

- Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions
- Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participating agreement

# Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

## Objectives

- Provide direct reimbursement to participating providers that render medically necessary, high-quality services to BCBSM members
- Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participating agreement and its administration
- Maintain and periodically update a printed or Web site directory of participating providers

# Quality of Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

## Objectives

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards
- Obtain continuous input from hospital through the Contract Administration Process
- Meet with provider organizations such as Michigan Health and Hospital Association to discuss issues of interest and concern
- Maintain and update, as necessary, an appeals process that allows participating providers to appeal reimbursement policies disputes or disputes regarding utilization review audits

# BCBSM Policies and Programs

BCBSM maintains a comprehensive set of policies and programs that affect its relationship with health care providers. These policies and programs are designed to help BCBSM meet the PA 350 goals and objectives by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the PA 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

## Provider Participation

Providers may formally participate with BCBSM or, with respect to some provider classes, providers may participate on a per-claim basis. To formally participate, providers must sign a participation agreement with BCBSM that applies to all covered services the provider renders to BCBSM members. To participate on a per-claim basis, providers must indicate on the claim form that they are participating for the services reported.

### Participation Policy

Participation for hospitals is on a formal basis only which means there is no "per-claim" participation. Hospital services rendered by a nonparticipating hospital are for the most part, not reimbursed. In order to participate, providers must meet all of BCBSM's qualification standards.

### Qualification Standards

All hospitals may apply to participate with BCBSM. Standards for formal participation include, but are not limited to the items listed below. Hospitals' credentials are periodically reviewed to ensure participation requirements are maintained.

Participating hospitals must meet the following qualifications:

- Michigan licensure as an acute hospital and/or as a psychiatric care hospital or unit
- Medicare certification as a hospital
- Accreditation from one of the following organizations:[1]
  - The Joint Commission on Accreditation of HealthCare Organization (JCAHO)
  - The American Osteopathic Association
  - The Commission on Accreditation of Rehabilitation Facilities

[1] This requirement may be waived if the hospital is located in a rural census category which is further explained in Exhibit A of the attached Participating Hospital Agreement.

- An accreditation organization approved through the Contract Administration Process defined in the Participating Hospital Agreement

- Compliance with applicable Certificate of Need requirements of the Michigan Public Health Code
- Written policies and procedures that meet generally accepted standards for hospital services to assure the quality of patient care and demonstrate compliance with such policies and procedures
- Compliance with generally accepted accounting principles and practices
- Governing board that is legally responsible for the total operation of the facility, and for ensuring that quality medical care is provided in a safe environment. The governing board, or as an alternative, a community advisory board responsible to the governing board, shall include persons representative of a cross section of the community who are interested in the welfare and proper functioning of the hospital as a community facility.
- Absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review, and absence of fraud or illegal activities

### Termination of Contract

The participation agreement may be terminated immediately by BCBSM if the provider fails to meet any qualification standard. It can be terminated by either party, with or without cause, upon 120 days written notice to the other party. Other stipulations for terminating the participation agreement are outlined in the Participation Hospital Agreement.

## Provider Programs

BCBSM strives to ensure that members receive appropriate and quality care through a combination of provider communications, education, and quality assurance programs.

### Utilization Management Initiatives

BCBSM works to ensure that only medically necessary services are delivered to members through utilization management and quality assessment programs. Details of these programs can be found in Exhibit C of the Participating Hospital Agreement.

### Communications and Education

BCBSM provides the following resources to communicate with and educate hospital providers:

- The Participating Hospital Agreement Advisory Committee is committed to providing support to the hospital community. The committee meets on an ongoing basis to offer advice and consultation on topics of interest and concern.

- *The Record*, *Hospital Update* and *Physician Update*, are BCBSM publications that communicate current information regarding billing guidelines, policy changes, clinical news and other administrative issues.
- BCBSM's Web site and online manual provide information on how to do business with BCBSM including billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements, the Participating Hospital Agreement, and its administration. BCBSM maintains and updates the Web site and manual as necessary.
- A provider directory on the BCBSM Web site which includes a current list of participating hospital providers
- Provider consulting services to offer assistance to facility staff
- Continuing medical education seminars
- The liaison process such as the Contract Administration Process though which hospitals provide input and recommendations to BCBSM regarding its programs and polices.

### Performance Monitoring

- Hospital providers are surveyed regularly to ensure that qualification standards are maintained and up-to-date.
- Suspected fraudulent activity, reported to BCBSM by providers, subscribers, and BCBSM staff, is referred to Corporate Financial Investigations for further investigation.
- Several types of audits are performed that work to ensure that providers rendered services appropriately and within the scope of members' benefits.

### Appeals Process

BCBSM's appeals process allows hospitals the right to appeal reimbursement policies or adverse determinations of a utilization review audit. The process is described in Exhibit D of the Participating Hospital Agreement.

## Reimbursement Policies

BCBSM reimburses participating hospitals for covered services deemed medically necessary by BCBSM. Payment is limited to the lesser of the facility's charge or BCBSM's reimbursement level.

## Covered Services

BCBSM reimburses only for covered services when provided by a participating hospital in accordance with member certificates.* Services provided at a hospital include but are not limited to:

- Room and board
- Surgery
- Maternity care and delivery
- Newborn care
- Emergency treatment
- Dialysis
- Physical therapy
- Chemotherapy
- Pathology and laboratory
- Radiology – diagnostic
- Observation bed
- Medical supplies

## Reimbursement Methods

Reimbursement methods are based on hospitals' Peer Group designation. Specifics of the reimbursement structure can be found in Exhibit B of the attached Participating Hospital Agreement.

### *Peer Groups 1-4 Inpatient and Outpatient Services*

Peer Groups 1 through 4 include larger and medium sized acute care general hospitals.

Inpatient services and outpatient surgery, laboratory, radiology, physical therapy, occupational therapy and speech therapy services are reimbursed on a prospective price basis.

Inpatient prices are determined using Medicare's diagnostic related groupings (DRGs), plus a hospital specific amount for capital, graduate medical education, uncompensated care and margin. Additional amounts are reimbursed for qualified catastrophic cases.

Prices for outpatient surgery, laboratory, and radiology services are based on freestanding provider levels, plus a hospital specific amount for graduate medical education, uncompensated care and margin. Prices for physical therapy, occupational therapy and speech therapy services are based on freestanding provider levels, plus a hospital specific amount for uncompensated

* Emergency services may also be covered by an accredited nonparticipating hospital.

care and margin. Freestanding provider levels are based on community pricing which is founded on the premise that payment for services provided in a hospital or non-hospital setting should be the same.

Hospitals have the opportunity to earn additional amounts on both their inpatient and outpatient payments under a Pay-for-Performance program.

Inpatient prices and outpatient surgery prices are updated annually using a formula that is based on the National Hospital Input Price Index (NHIPI). BCBSM does not guarantee that the annual updates will result in increased reimbursement. Hospitals' reimbursement and cost levels will be assessed every three years to determine whether there is a need for pricing adjustments.

Prices for outpatient laboratory, radiology, physical therapy, occupational therapy, speech therapy, and office-based surgery services are updated annually using the professional physician fee updates which is based on the Centers for Medicare and Medicaid Services' Resource Based Relative Value Scale system and a BCBSM conversion factor. BCBSM does not guarantee that the annual updates will result in increased reimbursement.

Other outpatient services may be cost-based until transitioned to community pricing. Outpatient cost-based services that are not routinely available through community providers will be transitioned to fixed statewide base prices using detailed claims information reported by hospitals in accordance with guidelines established by BCBSM.

## *Peer Group 5 Inpatient and Outpatient Services*

Peer Group 5 consists of small rural hospitals that are reimbursed a percent of charges for both inpatient and outpatient services, not to exceed 100 percent of their covered charges. The reimbursement for Peer Group 5 is hospital-specific. Hospitals must attest that their rates are at least as favorable as those for other non-governmental commercial insurers.

Hospitals will participate in a Pay-for-Performance program that will put a portion of the hospital reimbursement at risk.

The reimbursement levels for inpatient and outpatient services are updated annually using the formula that is used by Peer Groups 1 through 4.

## *Peer Groups 6-7 Inpatient and Outpatient Services*

Peer Groups 6 and 7 consist of psychiatric and rehabilitation hospitals and Medicare-exempt psychiatric and rehabilitation units of acute care hospitals.

Inpatient services are reimbursed based on the lesser of hospital's covered charge or BCBSM's per diem level. Annual updates are determined using the same update factor as Peer Groups 1 - 4. BCBSM does not guarantee that the annual updates will result in increased reimbursement.

Outpatient services are reimbursed the same as Peer Groups 1 – 4.

### *Non-Acute Services*

Other hospital-based non-acute services that can be provided under another provider class plan such as, but not limited to, residential substance abuse, home health care agencies, and skilled nursing facilities will be reimbursed using a hospital-specific cost-to-charge ratio set at a level not to exceed 1.0.

BCBSM may require that these services be considered "freestanding" and that they be reimbursed under a separate agreement. In such cases, the hospital will be granted participation status as a freestanding entity and will be given a reasonable amount of time to comply with such standards.

### *Alternative Reimbursement Arrangement*

BCBSM may consider alternative reimbursement methodologies such as "bundled" or "fixed" price arrangements covering all services per episode of care, where the reimbursement methodologies in this plan are not appropriate for payment of certain services, such as bone marrow transplants. All such alternative reimbursement methodologies will be determined through the Contract Administration Process.

## Hold Harmless Provisions

Participating hospitals agree to accept BCBSM's payment as payment in full for covered services. Member copayments or deductibles are subtracted from BCBSM's payment before the provider is reimbursed and are the member's responsibility. Participating hospitals must hold members harmless from the following:

- Balance billing for covered services
- Liability for services that are not covered because they are not medically necessary or are experimental, unless the member agrees in writing to pay for the services before they are provided
- Liability for covered services provided but not billed to BCBSM within a prescribed time frame

# Participating Hospital Agreement

The Participating Hospital Agreement is attached.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# Hospital Provider Class Plan

# Table of Contents

_Toc134322848

# Provider Class

A provider class includes health care facilities or health care professionals who have a contract or reimbursement arrangement with BCBSM to render services to BCBSM's members. Qualification standards and the services for which reimbursement is made may differ for the types of providers within a provider class.

## Definition

This plan includes all short-term general acute care hospitals, short-term acute psychiatric care hospitals, and intensive rehabilitation programs. Hospitals provide inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons requiring the daily direction or supervision of a physician.

## Scope of Services

The scope of the hospital's licensure covers a variety of inpatient acute and outpatient services. Hospital services range from in-hospital physician care, general nursing care, overnight stay, surgery including all related surgical services, obstetric, rehabilitation, anesthesia, lab, x-rays, equipment supplies, and drugs.

# PA 350 Goals and Objectives

Provider class plans are developed and maintained pursuant to section 504 of PA 350, which requires BCBSM to provide subscribers reasonable cost, access to, and quality of health care services in accordance with the following goals and objectives.

## Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." The goal is derived through the following formula:

$$\left( \frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

Where "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where "REG" means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

### Objectives

- Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions
- Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participating agreement

# Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

## Objectives

- Provide direct reimbursement to participating providers that render medically necessary, high-quality services to BCBSM members
- Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participating agreement and its administration
- Maintain and periodically update a printed or Web site directory of participating providers

# Quality of Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

## Objectives

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards
- Obtain continuous input from hospital through the Contract Administration Process
- Meet with provider organizations such as Michigan Health and Hospital Association to discuss issues of interest and concern
- Maintain and update, as necessary, an appeals process that allows participating providers to appeal reimbursement policies disputes or disputes regarding utilization review audits

# BCBSM Policies and Programs

BCBSM maintains a comprehensive set of policies and programs that affect its relationship with health care providers. These policies and programs are designed to help BCBSM meet the PA 350 goals and objectives by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the PA 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

## Provider Participation

Providers may formally participate with BCBSM or, with respect to some provider classes, providers may participate on a per-claim basis. To formally participate, providers must sign a participation agreement with BCBSM that applies to all covered services the provider renders to BCBSM members. To participate on a per-claim basis, providers must indicate on the claim form that they are participating for the services reported.

### Participation Policy

Participation for hospitals is on a formal basis only which means there is no "per-claim" participation. Hospital services rendered by a nonparticipating hospital are for the most part, not reimbursed. In order to participate, providers must meet all of BCBSM's qualification standards.

### Qualification Standards

All hospitals may apply to participate with BCBSM. Standards for formal participation include, but are not limited to the items listed below. Hospitals' credentials are periodically reviewed to ensure participation requirements are maintained.

Participating hospitals must meet the following qualifications:

- Michigan licensure as an acute hospital and/or as a psychiatric care hospital or unit
- Medicare certification as a hospital
- Accreditation from one of the following organizations[1]:
  - The Joint Commission on Accreditation of HealthCare Organization (JCAHO)
  - The American Osteopathic Association
  - The Commission on Accreditation of Rehabilitation Facilities

[1] This requirement may be waived if the hospital is located in a rural census category which is further explained in Exhibit A of the attached Participating Hospital Agreement.

- An accreditation organization approved through the Contract Administration Process defined in the Participating Hospital Agreement

- Compliance with applicable Certificate of Need requirements of the Michigan Public Health Code
- Written policies and procedures that meet generally accepted standards for hospital services to assure the quality of patient care and demonstrate compliance with such policies and procedures
- Compliance with generally accepted accounting principles and practices
- Governing board that is legally responsible for the total operation of the facility, and for ensuring that quality medical care is provided in a safe environment. The governing board, or as an alternative, a community advisory board responsible to the governing board, shall include persons representative of a cross section of the community who are interested in the welfare and proper functioning of the hospital as a community facility.
- Absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review, and absence of fraud or illegal activities

### Termination of Contract

The participation agreement may be terminated immediately by BCBSM if the provider fails to meet any qualification standard. It can be terminated by either party, with or without cause, upon 120 days written notice to the other party. Other stipulations for terminating the participation agreement are outlined in the Participation Hospital Agreement.

## Provider Programs

BCBSM strives to ensure that members receive appropriate and quality care through a combination of provider communications, education, and quality assurance programs.

### Utilization Management Initiatives

BCBSM works to ensure that only medically necessary services are delivered to members through utilization management and quality assessment programs. Details of these programs can be found in Exhibit C of the Participating Hospital Agreement.

### Communications and Education

BCBSM provides the following resources to communicate with and educate hospital providers:

- The Participating Hospital Agreement Advisory Committee is committed to providing support to the hospital community. The committee meets on an ongoing basis to offer advice and consultation on topics of interest and concern.

- *The Record*, *Hospital Update* and *Physician Update*, are BCBSM publications that communicate current information regarding billing guidelines, policy changes, clinical news and other administrative issues.
- BCBSM's Web site and online manual provide information on how to do business with BCBSM including billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements, the Participating Hospital Agreement, and its administration. BCBSM maintains and updates the Web site and manual as necessary.
- A provider directory on the BCBSM Web site which includes a current list of participating hospital providers
- Provider consulting services to offer assistance to facility staff
- Continuing medical education seminars
- The liaison process such as the Contract Administration Process though which hospitals provide input and recommendations to BCBSM regarding its programs and polices.

### Performance Monitoring

- Hospital providers are surveyed regularly to ensure that qualification standards are maintained and up-to-date.
- Suspected fraudulent activity, reported to BCBSM by providers, subscribers, and BCBSM staff, is referred to Corporate Financial Investigations for further investigation.
- Several types of audits are performed that work to ensure that providers rendered services appropriately and within the scope of members' benefits.

### Appeals Process

BCBSM's appeals process allows hospitals the right to appeal reimbursement policies or adverse determinations of a utilization review audit. The process is described in Exhibit D of the Participating Hospital Agreement.

## Reimbursement Policies

BCBSM reimburses participating hospitals for covered services deemed medically necessary by BCBSM. Payment is limited to the lesser of the facility's charge or BCBSM's reimbursement level.

## Covered Services

BCBSM reimburses only for covered services when provided by a participating hospital in accordance with member certificates*. Services provided at a hospital include but are not limited to:

- Room and board
- Surgery
- Maternity care and delivery
- Newborn care
- Emergency treatment
- Dialysis
- Physical therapy
- Chemotherapy
- Pathology and laboratory
- Radiology – diagnostic
- Observation bed
- Medical supplies

## Reimbursement Methods

Reimbursement methods are based on hospitals' peer group designation. Specifics of the reimbursement structure can be found in Exhibit B of the attached Participating Hospital Agreement.

### *Peer Groups 1-4 Inpatient and Outpatient Services*

Peer groups 1 through 4 include larger and medium sized acute care general hospitals.

Inpatient services and outpatient surgery, laboratory, radiology, physical therapy, occupational therapy and speech therapy services are reimbursed on a prospective price basis.

Inpatient prices are determined using Medicare's diagnostic related groupings (DRGs), plus a hospital specific amount for capital, graduate medical education, uncompensated care and margin. Additional amounts are reimbursed for qualified catastrophic cases.

Prices for outpatient surgery, laboratory, and radiology services are based on freestanding provider levels, plus a hospital specific amount for graduate medical education, uncompensated care and margin. Prices for physical therapy, occupational therapy and speech therapy services are based on freestanding provider levels, plus a hospital specific amount for uncompensated

* Emergency services may also be covered by an accredited nonparticipating hospital.

care and margin. Freestanding provider levels are based on community pricing which is founded on the premise that payment for services provided in a hospital or non-hospital setting should be the same.

Hospitals have the opportunity to earn additional amounts on both their inpatient and outpatient payments under a Pay-for-Performance program.

Inpatient prices and outpatient surgery prices are updated annually using a formula that is based on the National Hospital Input Price Index (NHIPI). BCBSM does not guarantee that the annual updates will result in increased reimbursement. Hospitals' reimbursement and cost levels will be assessed every three years to determine whether there is a need for pricing adjustments.

Prices for outpatient laboratory, radiology, physical therapy, occupational therapy, speech therapy, and office-based surgery services are updated annually using the professional physician fee updates which is based on the Centers for Medicare and Medicaid Services' Resource Based Relative Value Scale system and a BCBSM conversion factor. BCBSM does not guarantee that the annual updates will result in increased reimbursement.

Other outpatient services may be cost-based until transitioned to community pricing. Outpatient cost-based services that are not routinely available through community providers will be transitioned to fixed statewide base prices using detailed claims information reported by hospitals in accordance with guidelines established by BCBSM.

## *Peer Group 5 Inpatient and Outpatient Services*

Peer group 5 consists of small rural hospitals that are reimbursed a percent of charges for both inpatient and outpatient services, not to exceed 100 percent of their covered charges. Reimbursement for peer group 5 is hospital-specific.

## *Peer Groups 6-7 Inpatient and Outpatient Services*

Peer groups 6 and 7 consist of psychiatric and rehabilitation hospitals and Medicare-exempt psychiatric and rehabilitation units of acute care hospitals.

Inpatient services are reimbursed based on the lesser of hospital's covered charge or BCBSM's per diem level. Annual updates are determined using the same update factor as peer groups 1 -4. BCBSM does not guarantee that the annual updates will result in increased reimbursement.

Outpatient services are reimbursed the same as peer groups 1 – 4.

## *Non-Acute Services*

Other hospital-based non-acute services that can be provided under another provider class plan such as, but not limited to, substance abuse, end stage renal disease, home health care agencies, and skilled nursing facilities will be reimbursed using a hospital-specific cost-to-charge ratio set at a level not to exceed 1.0.

BCBSM may require that these services be considered "freestanding" and that they be reimbursed under a separate agreement. In such cases, the hospital will be granted participation status as a freestanding entity and will be given a reasonable amount of time to comply with such standards.

### *Alternative Reimbursement Arrangement*

BCBSM may consider alternative reimbursement methodologies such as "bundled" or "fixed" price arrangements covering all services per episode of care, where the reimbursement methodologies in this plan are not appropriate for payment of certain services, such as bone marrow transplants. All such alternative reimbursement methodologies will be determined through the Contract Administration Process.

## Hold Harmless Provisions

Participating hospitals agree to accept BCBSM's payment as payment in full for covered services. Member copayments or deductibles are subtracted from BCBSM's payment before the provider is reimbursed and are the member's responsibility. Participating hospitals must hold members harmless from the following:

- Balance billing for covered services
- Liability for services that are not covered because they are not medically necessary or are experimental, unless the member agrees in writing to pay for the services before they are provided
- Liability for covered services provided but not billed to BCBSM within a prescribed time frame

# Participating Hospital Agreement

The Participating Hospital Agreement is attached.